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Telephone: EUSton 3923 TAVISTOCK HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1 Telegrams: Epidauros, Westcent

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EDITORIAL

The Children's Health

It is a pleasure to read the report on "The Health of the School Child" which has recently been issued for the years 1948-1949.* Although school medical officers interchange reports, it is of much help to find the extracts which can be helpful collated under the different subject chapters. The report also announces the retirement of Sir Wilson Jameson and there is a fitting tribute to his wise guidance during his trying and difficult period of office from 1940 to 1950.

This is the first report since the inception of the National Health Service and a chapter deals with the co-ordination of this service with the school health service. Circular 179 of August, 1948, set out the principles by which this could be effected as foreshadowed in Circular 29 issued as early as March, 1945, and is quite properly printed in full. In general, it appears that the arrangements by which the regional hospital boards provide the specialists where the education authorities have so elected, are working satisfactorily. It is emphasised that the prevention and treatment are interwoven where child health is concerned and no doubt this has smoothed the way towards co-operation between the two parties in the first 18 months of the National Health Service.

The link between the hospital, the family practitioner and the school medical officer has also been carefully considered and it is emphasised that hospital reports in accordance with a circular from the Ministry of Health should be sent to both doctors. The joint responsibility of the school medical officer and the family practitioner is also recognised by the increasing consultations taking place before the child is referred for specialist examination by the former. The Chief Medical Officer makes it clear, however, that the pattern of consultation must be varied "according to local circumstances and personalities of the people involved."

A comment on the changing social conditions is that little reference is made to subnormal nutrition. The medical officers are becoming more used to the classifications and the results obtained are becoming comparable to judge by the examples quoted. An analysis for the whole country has not been given, so perhaps it can be assumed that there are still wide variations where there has been difficulty in interpreting the groupings. A very helpful note is given on the purpose of weighing and measuring. No warning has been given, however, that in the absence of recognised statistical criteria the results of comparisons can be very misleading; absence of these tests of significance give rise to startling headlines and the giving of unjustifiable impressions to the public in the national Press.

Turning to school meals, there is a hint of justifiable pride in the statement that the number of pupils taking school dinners rose from 2,500,000 in February, 1948, to 2,851,000 in October, 1949, representing a rise from 52·3% of the pupils in attendance to 53·2%. The service is a major social change brought about by the war and, despite the lack of suitable dining rooms in some schools, is definitely becoming part and parcel of the school life, especially as the standard of the food and its presentation rises.

The chapter on physical education emphasises the new outlook on this subject which was discussed in the previous report. Reference is made to the encouraging correlations which research has shown to exist between the biological growth and modern physical education. Gone are the old-fashioned "physical jerks"; the school is now concerned with the development of poise, vigour, endurance and nervous stability as part of the educational curriculum. School medical officers have been keen to arrange instruction for class teachers so as to enable them to deal with minor physical disabilities and will note with satisfaction that this has been possible in some areas. The physiotherapists and remedial gymnasts are, in this way, relieved of this load and able to concentrate on the disabilities which fall properly to their care.

In the chapter on the treatment of defective vision, the arrangements which came into force for the testing of vision and the provision of spectacles through the National Health Service are given in full detail. The supplementary ophthalmic service in relation to school children is explained and mention is made of the administrative memoranda which were issued to elaborate the principles relating to this service. It had been the intention, of course, that the ophthalmic work should follow the same course as other specialist work and a later memorandum stated that the Minister of Health had decided to ask regional hospital boards to arrange with local education authorities as quickly as possible for the taking over of school ophthalmic work done at clinics or on a sessional basis. It is known that this has already taken place in a number of authorities and it will be interesting to note the results of this arrangement in future reports. The unfortunate delay in the provision of spectacles after the National Health Service came into

*Pp. 92. Price 3s. net. H.M. Stationery Office.

force is chronicled, but happily the supply is now equal to the demand.

The results of medical inspection seem to be very much the same as previous years. When thought is given to the days before the establishment of the school medical service, it is interesting to note that 33% of the children on our school registers were examined by doctors at the periodic medical inspections. In addition, when consideration is given to the number of special inspections and re-inspections carried out, it seems probable that more than half the children on the registers were medically inspected during the years under review.

There seems to be no solution for the eradication of vermin in the children. Although the percentage is much lower than that found in the early days of the school medical service, and with due regard to the higher standards now demanded, it is disappointing to note that the present incidence is much the same as that before the war. Even this standard is only obtained through the unremitting effort of the school nursing staff.

In spite of the advent of the National Health Service, there is no falling off in the number of children who avail themselves of treatment at the minor ailments clinic. An analysis of the conditions treated shows a welcome continued fall in the number of cases of scabies and of impetigo.

The vexed question of tonsillectomy is discussed in relationship to Dr. Alison Glover's analysis. This shows strikingly the difference in operation rates between various towns and areas in the country. The report undoubtedly stresses the conservative outlook. In view of the long waiting lists for operation which exist in various regions, the plea is made for a careful scrutiny and periodical examination since experience has shown that many who have been on a waiting list for a long time no longer require operative treatment.

In the section on the school dental service, the now well-known effect of the National Health Service on the school dental service is recorded. It is noted that, within 18 months, the service had lost one-fifth of its effective strength, the same proportion which occurred during the whole period of the war. This is a sad commentary on the national service which hoped to give priority to children.

At the same time, there is a positive note in the advocacy of x-ray apparatus, and consideration is given to the forms of treatment which can most profitably be given in the prevailing circumstances.

The annotation on the statistical returns should prove helpful and there are useful sections on the numbers which can be inspected in a session and on orthodontic treatment.

The chapters on handicapped children appearing in previous reports in "The Health of the School Child" have been authoritative and comprehensive. The chapters on the diabetic child and child guidance in this issue are up to the same standard. It is heartening to note that there is now sufficient accommodation for diabetic children. This is an example of concerted action by the interested organisations and is to be commended. The management of the condition and the general care of these children are fully described.

Whilst the chapter on child guidance is of necessity concentrated, there are useful pointers for all who are concerned with the child's development. The way to prevent mental instability and the help which teachers can give in this direction are emphasised. In assessing the results of child guidance, the plea is made for the effective following-up of the children handled by this service. The suggestion is made that the future orientation of child guidance practice will largely depend on what is revealed by the later lives of those who have passed through the clinic.

In view of the recent discussions on the spread of tuberculosis amongst school children, the chapter on the prevention of tuberculosis is timely. The aims and methods of early detection not only amongst the scholars but also amongst the teachers and all who come in contact with the children are described. It is much hoped that the recommendations of the Joint Tuberculosis Council can be implemented at an early date.

The report is shorter than usual and the usual section on infections and mortality in school children has not been included.

The Care of the Aged and Chronic Sick

There are in this country at the present time over five million persons over the age of 65 years, of whom some 5% are in institutions of one sort or another. Prof. Thomson and his colleagues* have carried out a timely, interesting and intensive study of the care of the chronic sick in Birmingham. To this end they had much help from many sources ; they record their deep indebtedness to the health department, the staffs of the hospitals and voluntary agencies. These authors have brought into clearer focus a big problem of to-day and to-morrow. For on the one hand there is still a great deal of suffering by the aged sick left in the slums ; and on the other hand, precious hospital beds must not be misused when simpler and less costly institutional care can be given to those patients who cannot be provided for under tolerable conditions at home.

After careful study of over 1,000 patients in an institution for the chronic sick, it is estimated that one-fifth of these patients (those who require frequent medical attention or skilled nursing care) should be in hospitals ; one-fifth should be in mental hospitals or their annexes ; *three-fifths* could well return, either to their homes (provided that they were supported by the services of local health authorities, general practitioners and voluntary agencies) or to institutions, other than hospitals, providing domestic services and simple nursing, such as washing, feeding and dressing.

All who are engaged in day-to-day contact with this problem know well that it is easier to decide on what *should* be done, rather than what *can* be done. Many relatives will not, for good or bad reasons, have their old folk at home—indeed, many of the homes for the old folk seem to disappear for one reason and another during their stay in hospital. It must be admitted to our sorrow that necessary facilities for looking after the aged in the form of comprehensive domiciliary services are all too often inadequate to meet the problem.

We confess that we were shocked at the grim description of the condition of the old folk lying in infirmary beds. The prevailing spirit, or rather lack of it, was a complete apathy. We know that physical and psychological deterioration occurs in many long-stay cases where so often there is a subtle disintegration of personality and it is sad to read of the problems associated with incontinence and contractures of the limbs occurring in the bed-fast aged. A redeeming feature of this sombre story was the extraordinary devotion and skill of the assistant nurses and of the medical staff, all of whom were overloaded with duties.

The whole report of the investigation is in reality a plea for further study, clinical and social, on the problems of the aged. There is in this report a great deal of valuable "demographic data" not to be found elsewhere.

The reader cannot but be depressed with the description of the lot of those living at home. It was not thought possible that this sort of life could be seen nowadays even in darkest England. Let us quote one example, a woman of 41 with five children. In 1940 a bomb destroyed part of the house ; afterwards she had difficulty in walking and was found to have disseminated sclerosis. Another bomb killed three relatives who lived close by, and of course this did not improve her condition. For five years she had been sitting night and day in a wooden chair in the living room—she could not walk and had to be carried to bed. Both legs were oedematous due probably to immobility, and urine was trickling down them. She liked her heels to rest on a folded sack with the bare toes on the stone floor. There

* *The Care of the Ageing and Chronic Sick*. A. P. Thomson, M.C., M.D., F.R.C.P., C. R. Lowe, M.D., D.P.H., and Thomas McKeown, B.A., PH.D., M.D. Published for the Birmingham Regional Hospital Board by E. & S. Livingstone, Ltd., Edinburgh and London, 1951.

was a great pressure sore on the buttocks and the sacrum was in contact with the seat of the chair. She was in great pain and died of septicaemia two days after admission to hospital. When asked why she had not applied for admission earlier she said, " Every woman likes to be with her children as they grow up—but I can't help them any more." Nobody had suggested a district nurse or domestic help. Such cases were not exceptional—they were common. In the words of the authors, " we had not thought that life in England now could be so hard, so dreary and so desolate."

We wish that this study could have been made by practising Medical Officers of Health. Alas, one of our problems is that we do not seem to have the time. As the " general practitioners " of public health we have so many irons in the fire. But the lesson is clear. Somehow the time and the staff must be found, for the aged must have greater care. Hospital staffs should give more attention to detail, the emphasis must be on activity and rehabilitation and getting the patients back into their own homes before psychological and physical deterioration sets in. Dr. Bluestone, of New York, encourages the staff of the famous Montefiore hospital to go out to the homes and look after the " hospital " patients there. He finds it better and cheaper so to do. We might well encourage one or two experiments on these lines in this country.

We confess that our attitude to this report was one of criticism and scepticism at first, but we admit we have been convinced that this investigation by Thomson, Lowe and McKeown is a fine contribution to knowledge on a subject of pressing importance to every Medical Officer of Health.

Harlow Health Centre and Others

There seems no doubt that the honour of opening the first new Health Centre that meets the intention of Section 21 of the National Health Service Act, 1946, goes to Harlow New Town Development Corporation and the Nuffield Provincial Hospitals Trust, though Dr. Stephen Taylor, a member of the Corporation, has pointed out in the *Lancet* of February 2nd that it does not fall within the statutory definition which envisages the provision of the bricks and mortar by the Local Health Authority. However, Haygarth House, pleasingly named after one of the 18th century pioneers of social medicine named by the late Prof. Greenwood in his Heath Clark lectures of 1946, has been given the full co-operation of Essex County Council, who are renting the clinic accommodation and staffing it with doctors and health visitors. The first general practitioner (of the three who will eventually work from the centre) is also to do ante-natal and child welfare sessional work for the L.H.A. A whole-time A.M.O. of the county staff will also attend for school medical inspections.

Thus, although it is only temporary in purpose, and will be restored to its original purpose of two semi-detached dwelling houses when the population served exceeds 10,000, Haygarth House is, as Dr. Taylor points out, " a prototype of a true Health Centre because it brings the practitioners and clinics together." On its *multum in parvo* scale, it seems indeed to be a good model for new housing estates and rural conditions because it makes up in its intimacy and nearness to the people it serves for lack of such " frills " as *x*-ray, dispensary, doctors' common room, and so on. The cost of building and equipment has been about £6,500, of which the Nuffield Provincial Hospitals Trust presented £2,450 to enable the completion of the project.

The Nuffield Trust is playing a leading part in health centre experimentation. Other projects mentioned in the Trust's report for 1948-51 are the teaching health centre to be provided in a converted building (Darbishire House) at Manchester and the diagnostic centre for general practitioners at Corby, Northants. The Manchester centre, which will house six general practitioners, working as a group, two trainee practitioners, M. & C.W. and School Health Services, but no dentists, will serve a population of 16,500. In the later phase of its development it will take an active part in the medical education of Manchester students. This project is being financed by the Nuffield Trust and Rockefeller Foundation (£30,000 each), by the University in regard to research and teaching and by the City Corporation in regard to maintenance and non-medical staff (£3,500 per annum). As the centre is again not strictly within the meaning of the N.H.S.A., Section 21, it will not rank for grant and the corporation will find its contribution entirely from the rates.

Meanwhile, the L.C.C.'s first new centre is nearing completion at Woodberry Down, Stoke Newington, and the terms for renting doctors' suites (£350 per annum) have recently been agreed, though it will be recalled that the actual cost of providing and maintaining each suite is nearer £1,800 per annum. With the other projects for providing centres in new estates, for example, one on Harlow lines, at Nottingham, which may receive Ministry approval, there is a prospect that within the next few years some experience of various types of health centres may be acquired ; and that the general financial situation and the atmosphere in the medical profession may then permit a wide extension of centres where they are most needed and suitable.

Common Sense About Tonsils and Adenoids

We hope that the Public Health Service has paid the attention it deserves to Dr. F. P. M. Clarke's article, " Criteria for Tonsillectomy," in the *Medical Officer* for March 8th. Medical Officers of Health, School Medical Officers and their assistants have all an interest in matters relating to the naso-pharynx, and as often to them as to any practitioner or consultant engaged in curative medicine the question occurs as to whether in this particular child the removal of tonsils and adenoids is to be recommended. When we consider the extreme frequency with which the operation has been and still is carried out, we are the more surprised at the lack, remarked upon by Dr. Clarke, of authoritative guidance in the text-books of the experts. Certain it is that disease of the tonsils, real or alleged, has been accepted as the cause of a multitude of ills, from a tendency to colds to anaemia and general debility. Chronic infection and obstructive enlargement of the components of the lymphatic Ring of Waldeyer can and will give rise to any and all of the symptoms commonly attributed to them, and the important decision for differential diagnosis is whether, in each individual patient, the symptoms complained of are due to this cause and, if so, what is the best treatment. Removal by operation was once considered not only the method of choice but the sole procedure worthy of thought. A severe practical difficulty has now forced a reconsideration of this apparently so simple answer—the length of waiting lists at hospitals and the shortage of beds. Medical Officers of Health and School Medical Officers, as their experience of preventive medicine lengthens and the glamour of surgery in their hospital days is forgotten, tend more and more to prefer methods of treatment that avoid any kind of mutilation, whenever that is reasonably possible for the safety of the patient. Also, the Darwinian idea of the uselessness of vestigial structures may seem less obvious to-day, and he would be a bold man who asserted that the naso-pharyngeal lymphatic tissue had no function in the bodily economy. Thus there may be a danger among some to the opposite extreme and, remembering the observations of Dr. Alison Glover on the distribution of tonsillectomy by social class, whereby the pupils at Eton and Roedean predominantly were deprived of, and the equally healthy pupils at county grammar schools retained, their tonsils, they may come to believe that masterly inactivity will in all cases lead to an equally happy outcome.

The great recommendation of Dr. Clarke's survey is in the moderation of his conclusions. He recognises that real ills may follow continued hypertrophy of the adenoids and chronic infection of the tonsils. Obstruction caused by the former provides always an occasion for active treatment, as also does tonsillar sepsis. But he emphasises that defect

in the pharyngeal lymphatic tissue is not self-produced and that some prior cause for it, whether in sinuses or teeth, must be looked for and treated. In all or nearly all cases a course of local treatment is worth trial before surgical removal is advised, and if these considerations were borne in mind a great reduction in the number of patients referred for operation would be achieved. And, first and finally, there is no rule of thumb in this any more than in other human affairs ; every patient must be studied and his case assessed in its individual context and on its own merits.

A final thought occurs once more as to whether we are making the most of our opportunities in the School Health Service. Here, in the records of the past 40 years, especially if correlated with findings in the services, in industry and when the children of the past reappear as the parents and even grandparents of the present, is surely material for a definitive answer to all questions concerning the natural history of tonsils and adenoids and the end results in benefit to the patient of treatment and the lack of it. The studies that exist, of Clarke, Glover and others, are drawn from this field, but there is plenty of room for other explorers. There is also, of course, a wealth of experience from abroad, European and otherwise, which we ignore at our cost, and one of the merits of Dr. Clarke's thesis is that he has freely drawn upon it.

Mass Radiography Survey of Islington

The opening of a static mass miniature radiographic unit at 32, Drayton Park, Islington, on February 7th, marks an interesting departure by the North-West Metropolitan Regional Hospital Board. In contrast with the usual essentially migrant method of using M.M.R. units, the intention in this instance is to achieve a complete survey of the whole adult population of a London borough. Islington's population is 235,645, the largest in the administrative county after Wandsworth, and it is intended to keep the unit at Drayton Park for an initial period of 12 months and longer if necessary to obtain maximum cover. The circumstances of Islington make it possible that the survey will ascertain a larger proportion of hitherto unrevealed active cases of tuberculosis than is normally to be expected.

This venture is a co-operative one, since the London County Council have made the premises available and Islington metropolitan borough council is giving the scheme publicity. We shall await the outcome with interest.

Some indication of public willingness to use a static unit is given by the experience of that set up by the N.E. Metropolitan Regional Board in premises provided by the City of London Corporation in November, 1950. Here Dr. Charles White reports* that nearly 51,000 persons, mostly working but not living in the City, presented themselves in a period of 14 months.

Living in Flats

A recommendation that homes for as many people as possible should be provided in houses and maisonettes, even in areas where there must be high densities of building, is contained in a report sent by the Minister of Housing and Local Government, Mr. Harold Macmillan, to local authorities in England and Wales concerned with the building of flats. The report† is the work of a sub-committee of the Central Housing Advisory Committee under the chairmanship of Mr. Henry Brooke, M.P., and with Prof. J. M. Mackintosh as a member, set up to consider the social needs and problems of families living in large blocks of flats.

The difficulties of life in flats are attributed to greater exposure to noise, lack of privacy, and the absence of a separate garden or yard. Suggestions for meeting them by providing playgrounds, individual gardens and other facilities are made, but for the family with young children it is felt that there is no adequate substitute for a house. Attention is drawn to the lack of houses and maisonettes in most of the estates built in central areas since the war. The decision to exclude them is attributed to the belief that they are incompatible with high densities, and to the fact that bigger subsidies are payable on flats than on houses built on sites of the same value. In an appendix to the report, figures are given showing that some houses can be included even in estates with the highest densities.

The Committee call attention to the importance of close consultation between the housing manager and architect from the outset in planning an estate of flats. They have also taken into consideration the need to make the best use of restricted resources in money and land, and have avoided recommendations which would unduly increase costs and, therefore, rents.

The General Practitioners' Pool

The rapid adjudication made by Mr. Justice Danckwerts on the question of the determination of the pool to be available for general practitioners' remuneration in accordance with the Spens Committee's recommendations is a matter for congratulation to the General Medical Services Committee of the B.M.A. and to our colleagues in general practice under the National Health Service.

The point which is of particular interest to us is that for the first time an impartial referee has laid down that the " betterment factor " representing the difference in the standards of professional earnings in 1939 and in 1951, " having regard to the change in the value of money since 1939, to the increases which have taken place in incomes in other professions and to all other relevant factors," is 100, and that it was 85 in 1948. It will be recalled that the so-called " betterment factor " was a part of the case for salary revision in the public health service and that the arguments for our side in the Industrial Court were related to the Spens recommendations regarding G.P.s and specialists. The Danckwerts adjudication, therefore, has a very real bearing on the case now being assembled for the reconsideration of the Departmental Medical Officers' scale.

Foot Health

We were glad to see, in the Ministry of Health's *Monthly Bulletin* for February, evidence in the shape of the article contributed by Drs. A. F. Alford and Mary Gorrie, that both the departments with which we are closely concerned have continued their interest in the field of foot health. The recent film " Your Children Walking," made by the Central Office of Information for the Ministry of Health and the C.C.H.E., was further evidence that the medical element in the Ministries is very much alive to the importance of the subject.

On the other side of the picture, we much regret the recent ruling by the Minister of Health against the London County Council's application to extend the foot clinic facilities in its area. In its evidence to the Cope Working Party on Chiropodists, the Society's witnesses expressed the view that care of the feet in all ages was one of the most popular and, up to school-leaving age, one of the most truly preventive services provided by local authorities, and it will be recalled that the Cope report went out of its way to recommend that local authorities should continue to operate and to develop foot clinics.

The Society is giving its support to the second National Foot Health Week organised by the Foot Health Educational Bureau from June 16th to 21st. We feel that the M. & C.W. and School Health Services in particular can play a great part in seeing that the damage is not done in the early formative years.

Medical Officer* (February 2nd, 1952), **87, 48.

† Living in Flats, Report of a Sub-committee of the Central Housing Advisory Committee. H.M. Stationery Office. Price 1s. 6d.

HOUSING AND TUBERCULOSIS *

The Chairman (**Dr. W. G. Clark,** *Medical Officer of Health, City of Edinburgh; President, The Society of Medical Officers of Health*):

The reason for this joint meeting is that the last was such a success. The Secretary-General of the *NAPT* approached us a short time ago and suggested another joint meeting between the National Association and the Society, and my Society accepted that most warmly. It was further suggested that the President of the S.M.O.H. should occupy the chair, and that is why I am here this afternoon.

I acceded warmly to this request because there are few problems more intricate than the one we are discussing to-day. There are many aspects of it which this meeting may wish to discuss; there are two which are immediately important. First, the association between overcrowding and tuberculous infection. Secondly, the results of rehousing sufferers from tuberculosis. A third matter for discussion might well be the impact of housing on the domiciliary treatment of the tuberculous cases. We remember the work of Chalmers in Glasgow, who in 1913 said that for every age group the mortality rate varied directly with the size of the house, being at its highest in houses of less than three rooms. Then stepped in the statistician Greenwood, who in 1926 was unable to achieve any consistent conclusion from official statistics, and criticised the existing housing indices. He pointed out that the massed detail of official statistics were too complex to yield any decisive answer.

Again, Peters, of the Department of Health for Scotland, showed that the mortality rate from tuberculosis was 340% greater in houses of one apartment than in houses of four apartments and more, but emphasised that the specific effect of overcrowding, as measured by the average number of persons per room, was not consistently clear.

Then the new M.O.H. of Glasgow, Laidlaw, in 1933 confirmed Chalmers' findings, but showed that the difference was most apparent amongst those aged 15 to 19, and especially amongst the males of this group. In 1946 he added further evidence of the association between overcrowding and tuberculosis.

But in recent years doubt has been thrown on the specific effect of overcrowding on the incidence of tuberculosis, by McKinlay in 1947 and Lockhart in 1949. McKinlay studied changes in mortality rates from tuberculosis between 1911 and 1933 in relation to changes in housing standards and found no correlation whatever. It is possible, of course, that Greenwood's criticism of the complexity of "the massed data of official statistics" is at the root of such negative results. Lockhart, comparing the housing of tuberculous families with that of the population as a whole, showed that there was a greater concentration of tuberculous families in smaller houses, but that there was no uniform increase in the incidence of tuberculosis with overcrowding.

Bromfield, in my office in Edinburgh, in an unpublished study has shown that the pulmonary tuberculosis notification rate per thousand of our Edinburgh population during 1946 was 0·845 in those living not more than one to a room; it was 1·313 in those living two to a room; 1·519 in those living three to a room; and 1·569 in those living more than three to a room. The only statistically significant difference revealed is between those living not more than one to a room and the other groups.

Stein, again in Edinburgh, in 1950, in a study of respiratory tuberculosis in relation to housing conditions in Edinburgh before the recent war† emphasised Greenwood's earlier criticisms of existing housing indices and his warning of the unsuitability of mass official statistics in such investigations. She used the density of house occupation as an index to overcrowding, and she came to the conclusion that "in a well-defined area which can be sub-divided into meaningful units, the relation between high density of domiciliary occupation and prevalence of respiratory tuberculosis is overwhelming." She has attempted to explain the failure of other investigators to reach such definite conclusions, but it is clear that this meeting can usefully discuss what must now be done to settle this problem once and for all and provide real statistical information on this problem.

Turning to the rehousing of the overcrowded tuberculous patients, Edinburgh Corporation for some years has been giving a complete priority to tuberculous cases in the ratio of one to nine of all their new and requisitioned houses. This policy is aimed at reducing the number of family contact infections; but we have now to consider its effect on the spread of tuberculosis within those new housing areas. The methods by which such a study can be effectively carried out form a useful subject for discussion to-day. I am obviously drawing your attention to the fact that the methods used by Webb, Stewart and Sutherland, of the Oxford Institute, in their study of the spread of tuberculosis from house to house in Northampton* are not equally applicable throughout Britain, since variations in the type of housing involved make the statistical method used not appropriate in every case. They did reach the conclusion that the incidence of tuberculosis in those living next door to houses with an existing case of tuberculosis was greater than could be accounted for by chance. How can we assure ourselves that in trying to protect the family contact we are not making the error of disseminating this infectious disease throughout new housing areas?

That is my short introduction. That is my confession of ignorance of this problem; and I hope that this discussion to-day will enable us Medical Officers of Health to go home and act in the interest of the community as a whole, to try to prevent the spread of infection.

Anthony Greenwood, M.P. (*Member of Council, NAPT*):

I am particularly nervous, not only at talking to an audience which consists largely of specialists in the field of health work, and particularly tuberculosis, but also because I am speaking in the presence of one particular specialist in this field to whom I personally owe a very great debt for the education which he gave me in the social importance of tuberculosis. That, of course, is Dr. Chalke, whose work in South Wales was a most useful stimulus to research in this field, and which to some extent set the pattern for later work which has been done. The work that he did there leaves no room at all for doubt as to the close relationship between poverty, and all the things that go with poverty, and the incidence of tuberculosis.

Our Chairman said that Greenwood was unable to draw any consistent conclusion from official statistics. Well, I think that may be the position in which I am myself this afternoon, and in which perhaps you also will be when I have finished my talk, because I have regarded my function as not being that of discussing what we might call the medical aspects of this problem, but that I should approach it as a politician who bears some responsibility for the country's housing policy. We must first of all look at the problem as it is and see how vast this matter is of getting adequate housing standards.

In 1939 we had in this country just about 12,000,000 houses. But those were not adequate even at that time to the requirements of the population. Housing conditions were very bad indeed; in England and Wales 5 out of every 10 houses consisted of two rooms or less; in Scotland the figure was as high as 44 out of every 100 houses which consisted of two rooms or less. When overcrowding surveys were made in the middle 'thirties, they revealed probably a still more serious situation.

* Report of a joint meeting of the National Association for the Prevention of Tuberculosis and of the Society of Medical Officers of Health, held in the Great Hall, B.M.A. House, London, on Friday, February 1st, 1952.

† *Brit. J. Soc. Med.* (1950) **4**, 143.

* *Brit. J. Soc. Med.* (1951) **5**, 13.

Let me say at this stage that the standard of overcrowding which was taken for official purposes was not an unduly high standard. Roughly, it was two persons to a room ; children under 10 counted as half a person ; a baby under 12 months old did not count at all. If you work it out it means that you could have a married couple with six children under 10 years of age and a baby under one year old, and they could occupy three rooms, each 10 by 10 feet square, without being overcrowded for official purposes. Well, that does not seem to me to be a proper standard of housing accommodation. But even when we apply that somewhat loose standard we find that, before the war, 4 out of every 100 families in England and Wales were overcrowded, and the relevant figure for Scotland was 25 out of every 100. But that, of course, was a national average, it covered the good places and it covered the bad places, and there were parts of this country where the figure was considerably worse. In Shoreditch, 17 out of every 100 families were overcrowded, in Sunderland the figure was 21, in Hebburn it was 25. Some towns considered that the overcrowding standard was too lax, and towns like Leeds adopted what they called a bedroom standard, which meant leaving the living-room out of the calculation, and when that was applied it was found that, whereas Leeds officially was regarded as having only 3 out of every 100 families overcrowded, when the bedroom standard was applied the figure rose to 21 out of every 100 families, and the overcrowding figure before the war probably ought to have been something like 10 times the official figure which was given at the time.

It was not only a question of overcrowding, it was partly a question of the condition of the property at that time. Of those 12,000,000 houses before the war, 4,000,000 had been built since 1914, most of them after about 1921. Another 4,000,000 had been built between 1860 and the outbreak of the First World War, and the remaining 4,000,000 had been built before 1860. The age of the property meant that to a large extent it was inadequate to modern requirements. In the London boroughs, for example, in 1938 it was found that 9 out of 10 working-class houses were without bathrooms. In 26 counties in this country, half of the rural dwellings had only earth or bucket closets, and in Lancashire towns even to-day it is still, in some towns, unusual to have indoor closets, and one finds the position where 20 houses probably share four closets, which are at the bottom of the street, and in many cases even across the main road.

Well, that is a broad picture of the situation as it was when war broke out in 1939. It was not a good situation. We had not made any tremendous progress in clearing the slums, although we had started on that work, and by 1939 only half of the houses which had been scheduled for demolition under slum clearance schemes had actually been demolished, and we had on our lists waiting to be demolished a quarter of a million houses which had been condemned as unsuitable for human habitation.

Then when the war came along house building virtually ceased. During the war only 200,000 houses were built, and most of those, of course, had been started before the war began. During the war, 200,000 were destroyed completely and another 250,000 were rendered uninhabitable, and of the remaining houses in the country a third were damaged in one degree or another. So that considerable repairs were needed after the war to the bomb-damaged houses. But in the meantime the position had been made worse by a number of other factors. First of all, there had been an increase in the population. To-day we have got about 2,500,000 more people than we had in 1939. The large number of war marriages had produced a consequent increase in the number of families which had to be housed. Full employment during and since the war has increased the effective demand for houses, and of course to-day many old people are in a better position to keep on their houses than they were before the war.

All those factors have increased our difficulties since 1939, but of course the main difficulty has been the increasing obsolescence of the houses that we had. If you take a very conservative estimate of the length of useful life which a house has, 100 years—and it probably ought to be less, 75 years or 80 years at the outside—we need 125,000 houses every year in order to keep pace with the effects of obsolescence on existing houses. That means that since 1939 we ought to have built about 1,500,000 houses, just to keep pace with obsolescence. Really, we are faced with this position, that we needed 250,000 houses to replace the ones which were condemned before the war, another 200,000 to replace the ones which were destroyed during the war, and another 1,500,000 to keep pace with obsolescence. Then we must not forget that there are about at least 2,000,000 houses which to-day are more than 100 years old—that is taking half the figure of the houses which before the war had been built before 1860, a very conservative estimate.

If you add that up it means you have to provide, since 1939, 4,000,000 new houses to keep pace with the situation One must not forget that in another 20 years' time, at the rate of obsolescence to which I have referred, another 2,500,000 houses will have become obsolete. That means between 1939 and 1972 we shall have had to provide 6,500,000 houses just to keep pace with obsolescence.

What have we done so far ? There were 200,000 built during the war. Since the war, including pre-fabricated houses, we have built just about 1,250,000 new dwellings. That means that since 1939, towards our target of 6,500,000 by 1972, we have only succeeded, so far, in providing 1,500,000, which leaves us just over 5,000,000 houses to build in the next 20 years, which means a minimum output every year of 250,000 houses.

There, of course, one comes into extremely troubled waters ; it is a highly technical problem, one very difficult to discuss without treading on people's political corns, but looking at it purely on the statistical basis, it does seem the figure we have got to achieve is 250,000 per annum, and to what extent that is a practicable figure I hope Mr. Walls will be able to instruct us later on. But I do think we ought not to forget, from the health point of view, that it is not only the houses which are necessary. We have got to keep our schools up to date so that our children are educated in a healthy atmosphere. We badly need new hospitals, we need new health centres, and we need many other new things in the world of health. Then we have got to see that our factories are kept up to a reasonable standard.

My own view is that it is very difficult to exceed an average output every year of 200,000 houses unless you lower the standard, which to some extent may not be a bad thing, unless you stop the building of hospitals and schools and unless you cut out to a large extent new industrial development. But if we are to have continuing shortage and if we can only put up 200,000 houses a year, it will not only be a continuing shortage but it will be a worsening shortage, which will only be compensated by what will almost certainly be a drop in the population during that time. This means that it becomes increasingly important to see that the houses which are built are properly allocated. It is for the politicians to try to create conditions in which the maximum building programme can be put into effect, but it is for Medical Officers of Health and social workers to tell us what is the best use to which the houses shall be put when they are built, and I hope later to hear the views of the speakers upon, for example, the points schemes which are operated by local authorities, the problem of rehousing tuberculous patients so that they are within reach of their work, and of the amenities that they want. I want to hear their views upon segregation, upon which you, Mr. Chairman, touched ; I want to hear an unbiased discussion of the relative priorities that various classes like the tuberculous, the cripples and other sick people should have in this problem of rehousing, and I want particularly to hear what part education can play, because it is in the sphere of education in tuberculosis work that the *NAPT* is especially interested.

H. D. Chalke, O.B.E., M.A., M.R.C.S., L.R.C.P., D.P.H. (*Divisional Medical Officer, London County Council*):

It is 20 years since I last had the honour of speaking at a conference of the *NAPT*. On that occasion I was fortunate enough to follow Dr. Bardswell, and Dr. Bradbury, who gave us an account of his most excellent investigation in Tyneside. I recall that on that occasion also housing figured very prominently in the discussion. In considering what I should say to-day that might be of interest, I asked myself first of all, "What progress has been made in our knowledge of the association of adverse housing conditions and tuberculosis?"

I speak to-day not as a tuberculosis officer or chest physician because, perhaps inadvisedly, I have now forsaken this work for administrative public health. But I may be able to speak a little more dispassionately now than I did in those days when perhaps I showed a certain amount of 'dispensary' bias.

In the literature of the past 20 years, the causative factors in tuberculosis do not appear to have been assessed with real satisfaction: but, at least, the mal-influence of adverse social circumstances is without question. There has been much painstaking and admirable research, and a vast amount has been written and a good deal said, some of it rather repetitive. But in all this there has certainly been no unanimity of opinion. For example, is overcrowding more important than the number of people in the house? Some say it is. Does the size of the room matter? This appears to be a specially noteworthy factor in factories. Again, is the chief influence the number of persons at risk? Here again there is a conflicting view. I was myself surprised to discover that in one area where the incidence of tuberculosis was extremely high—and the health standard poor—the four- and five-roomed houses were affected to a relatively greater extent than the small two- and three-roomed houses.

There is ample evidence that children of tuberculous parents, the poorly housed in particular, are more liable to attack than other children. But even in this group, some 80% escape. The answer is still speculative.

Again, is it true that infection after childhood is not due to environmental factors? Many believe that it is. So there seems to be a great amount of territory awaiting exploration by the research worker in tuberculosis. In the meanwhile, we had better content ourselves with the fact that tuberculosis is an infectious disease which is particularly dangerous where the young are concerned, and when the infecting dose is large and repeated.

I think, although this is a discussion on the housing of the tuberculous, that we should not confine ourselves to the problem of housing alone. We should look upon the term "housing" from its widest angle, because the other places in which people pass so many hours of their lives, factories, schools, village halls—quite a notable factor in rural areas—are very significant in this question of spread of infection among contacts.

The recent investigation by workers from the Institute of Social Medicine, Oxford, must cause some disquiet; if what they say should prove true it must be a factor of great consequence; it cannot fail to have a very significant effect not only on our housing programme but also on the status of the consumptive. You remember that it was found that 20% of affected houses in Northampton were grouped in pairs, or three, or more. In a Welsh seaside town I found that 27%, in a quarry village 33% (and I think an even greater percentage than that in some of the smaller villages), were so grouped, in twos, threes, and so on; but I must say I was unable to come to the conclusion that this was associated with anything but industry, adverse social circumstances generally, movement of families and bad health education.

This is a matter which requires most urgent and immediate further investigation. It is one of the most important pronouncements in the field of tuberculosis investigation of recent years.

When I was asked to speak here I thought that I should try to produce some recent figures, so I attempted a very short investigation in a London borough, inspired by Dr. Hartston. All I did was to get all the positive sputum cases, 600 or 700 of them, divide them into groups as to whether the housing was good or bad, the only criterion being the presence or absence of a separate bedroom for the infectious patient. I prepared a form (Fig. 1) which took very little time to complete, the whole thing was done in a week, and I am indebted to health visitors and to Dr. Price, the chest physician, for giving me all the facilities to do this. The information that I gathered—and the investigation is by no means complete—is indeed quite interesting. The number of houses in each group proved identical, in other words, there were just as many houses in which the positive sputum cases did not have a separate bedroom as there were in which they did. As was to be expected, the number of contacts under 15—this is the point that matters—was very much greater in the bad houses, that is why they were bad houses; therefore there were more children at risk. In the good houses the spread to other members of the family took place in one house in every eight, and there was just 1·1 secondary case per house. But in the bad houses spread took place in one house in five—1·3 cases per house. In

FIG. 1

FORM TO ASCERTAIN HOUSING CIRCUMSTANCES OF SPUTUM-POSITIVE TUBERCULOSIS CASES IN A LONDON BOROUGH

Sp + cases only

Name..... Age..... M/S.....

Date notified.....

Address .....

Housing

Good .....

Bad No separate bedroom.....

Overcrowding.....

	Number of Home Contacts		
	* Active Primary T.B.	* Other T.B.	Tuberculin reaction (+) or (—)
Over 15			
Under 15			

* Further details

Relationship	Age	Sex	Disease

bad houses 90% escaped pulmonary tuberculosis, as compared with 95% in good houses. So even under adverse conditions a large number of contacts under 15, where infectious cases were living in close contact with them, escaped infection. There was no significant difference, incidentally, in the amount of marital tuberculosis in each house, although I believe recent investigators seem to think this factor of more consequence than we thought at one time.

These figures have, I think, some statistical significance. My statistical friend Mr. Benjamin tells me they have, particularly when we remember that many of the families in good houses have only recently been rehoused from bad ones.

These results are quite preliminary, and perhaps, Sir, I might take this opportunity of asking some of my colleagues, medical officers of health and chest physicians, if

they would perhaps carry out a little investigation of this sort in their own neighbourhoods. We might then get something of interest to show us what is happening in 1952 in various parts of the country.

Now there are other influences of unsuitable housing as well; apart from opportunities for infection, there may be physical, mental and economic effects, closely related to the breakdown of resistance and the response to treatment; these factors are important not only for those who return from sanatoria but for those who are awaiting sanatorium treatment also.

I have always believed that the damp house is of particular significance in this breakdown of resistance. In certain villages in Wales, where every other factor seemed identical, villages seemed to escape very often in those places where the subsoil was porous and the houses not damp; and in villages where the incidence of pulmonary tuberculosis, or the mortality from it, was high, there was a correspondingly high death-rate from pneumonia and bronchitis and so on.

Another recent contribution by Dr. C. R. Lowe and Dr. J. E. Geddes (*Lancet*, 1952, **1**, 92), shows us that 20% or more people in sanatoria are only there because there is no suitable accommodation for them to go back to. In other words, they are blocking sanatorium beds. This is a parallel problem, of course, to that which we are now facing with regard to the aged.

Liaison between the local authority and chest clinic is essential; not only for priority rehousing, but in order to better, if possible, the existing home. Although the tuberculous have a very strong title to housing priority, we must take a sane and balanced view of their needs and their claims. Prof. Davies has told us a lot about this in an admirable article in the *NAPT Bulletin* (1951, *Aug.*). There is a tendency to forget the needs of other sections of the community, and to consider that the label "tuberculosis" is an "open sesame" to a new dwelling. This task of sifting the claims requires very great care and very great experience. It can only be left in the hands of a competent medical officer on the public health staff who knows what he is doing, and works in very close harmony with the chest physician. No one will deny, for example, that there is high priority for a household where there are many children in contact with the open case; but there should be priorities within priorities. We should consider such factors as whether the children have been infected, the number at risk, their ages, and whether the house is damp and, probably more than anything, the standard of health education in that house, which is an index of the advantage likely to be gained by moving them to a more salubrious abode. The type of new accommodation which is chosen or allotted is also important, and I wonder how many medical officers who are engaged in this, have any knowledge as to where the people are likely to go. I am afraid in London a large number of the rehoused go into flats. There are often social reasons connected with their work, rent, and so on, which preclude these people from taking advantage of housing estates outside the metropolis, and they rehouse themselves in flats. Some people may think it is better to rehouse a tuberculous person anywhere than not to rehouse him. I am not of that school. I feel that the question of where he goes to is of very considerable importance.

Finally, I wonder if the great clamour nowadays for more sanatorium beds is another sign of our times, which are producing a disease-conscious populace, and in which prominence is being given to the healing art rather than preventive medicine: times when positive health is passing its infancy and early years in comparative obscurity. Is it rank heresy to say that all these extra beds are not really necessary? Sanatoria, it may be, are not without their dangers, the dangers of infection, the dangers of reinfection, particularly if this is with resistant organisms after modern methods of treatment, and so on. I feel that the stay in sanatoria may be restricted to that period necessary for adequate initial treatment and for the inculcation of those ideas of health education which can be started in the dispensary: and, of course, rehabilitation. It may be agreed that it is not more beds we want, but more hostels, more halfway houses, more night sanatoria and residential nurseries, more homes, and small factories for those who remain infectious; *small* factories are rather important, and above all, I think, shelters. I believe that in London the number of shelters issued by local authorities to be used by people who have returned from sanatoria can be numbered on the fingers of one's hands. I cannot believe that in this large city there is not room for very many more shelters; this, of itself, would do much to solve the housing problems of the tuberculous. Buckinghamshire is setting an example.

In conclusion, has the present housing shortage tended to overshadow the old-established and well-tried principles of prevention? Are we forgetting the lessons of the colony for the tuberculous, where the contact child grows up with a greater chance of escaping active disease than do the children in the outside world? I often compare the problem with malaria—although the analogy is not perfect. You remember the Army in Macedonia, completely immobilised by the disease; and the people who, to prove the worth of simple preventive measures, lived in a malarious swamp there—and escaped! Could we think, perhaps, a little more on these lines? On the one hand, you will agree we must do our utmost to see that the tuberculous population is properly housed; on the other, we should combat with the utmost vigour the belief which is ever increasing, that there is little future for the tuberculous family unless they are rehoused, and rehoused quickly. Education, guidance, supervision and examination will, in a great number of cases, enable them to offset adverse environmental conditions, and enable them also (as I said at a similar meeting 20 years ago) to reap to the full the advantages of better housing conditions when they come their way. [*The London County Council accepts no responsibility for this speaker's statements or opinions.*]

Mrs. H. M. Nicholson (*Welfare Officer, Tottenham Chest Clinic*):

The picture of housing, although extremely black for the population as a whole, has been over the last 10 years much more hopeful for the tuberculous than it was.

I was formerly on a housing committee of a borough outside London. We had an excellent housing policy; we built houses by direct labour, some better, some not so good, according to the government policy of the time. We had an excellent borough engineer, and a staff of building workers who seemed to be possessed by a vocation to build. We did very well, but I always remember that we never allocated houses otherwise than on an overcrowding basis and gave no advantage to tuberculous patients. I can remember asking why, and the answer was, "It's not our business to house the tuberculous; they are the care of the county authority and if they are to be rehoused the county must buy its own land and build its own houses." It was a very narrow point of view, but we were just ignorant people, and in those days there was no definite move that social conditions should be part of the treatment of the tuberculous.

I came into tuberculosis in 1943, the year in which Memorandum 266 was issued by the government of that day. I suppose that was the most human circular ever issued, because it completely changed the whole world of tuberculosis. It meant that an authority which was willing and determined to implement all the permissible clauses of that circular could do almost anything for the relief of tuberculosis. Almost over-night housing became the first concern of doctors, welfare workers, and everybody. We realised that the nation was spending many thousands of pounds on the treatment of tuberculosis, but that patients were returning to precisely the same conditions that had often caused their disease.

About 1944 I began to write housing letters. I was fortunate in my area. Tottenham, again, was a borough

that had had a sound housing policy for many years ; they always had been consistent in considering that housing should be the first concern of any authority. In those days it was amazing what one got away with in the re-housing of the tuberculous. Almost any type of medical certificate was accepted, and, with the limited number of houses at the disposal of the local housing committee, over the first years I had about 10% for tuberculous patients.

We were also lucky because in Tottenham we had a very large L.C.C. housing estate, and the L.C.C. was really most generous in accepting patients living on that estate for larger and better accommodation if there was a case of tuberculosis, or if there was overcrowding.

It was not until about 1946 that things began to tighten up for the tuberculous. The large amount of requisitioned property had gone, and housing was not keeping pace with the people returning from evacuation and the Services. Allocation and pointing changed completely.

By that time everybody had realised that a doctor's certificate was necessary to get anywhere, so everybody had a medical certificate for nerves, or something like that, which gave them five points to start with. That did not mean very much, because the public were always much aware of the points system. For instance, at one time if a man and woman married, and the woman stayed at home with her family and shared a bedroom with her sister, and the man stayed in his room and shared a room with somebody, that gave a great number of points. It was amazing the number of people who married but who could not share a room anywhere !

It is one of the tragic things about shortages that nobody is quite honest any longer, and it became more and more necessary to investigate and check. Tuberculous people fell into a certain amount of disrepute with the housing management and housing officers. My housing manager at Tottenham and his staff have the most difficult task imaginable. They are open to pressure from all sides. Many years ago tuberculous people were quite willing to live in their slums, and to share beds and to share rooms, and to have no facilities at all for decent nursing ; they accepted it without any protest. But, of course, through our propaganda we have changed all that.

Most significant of all, the patient himself became aware of his danger and of the danger to his family. The tragic aspect of this propaganda was that we were years ahead of what any government could do to implement what was recommended. I often feel that we have defaulted on these people. When the patients in families became aware of that propaganda, demands poured in to an alarming extent, and now any housing manager goes in fear of physical violence when he has to face up to these frantic people and say "We cannot rehouse you. You must be so long on the housing list before you can possibly be considered."

The position of a man or woman who becomes suddenly aware that good food, good housing, fresh air, would save his dependants from a dangerous disease is something too shocking to be imagined. He brings pressure to bear from every side. He writes to the Royal Family, he writes to the Press, he writes to his M.P., he writes to every member of the local council, every member of the housing committee. We are bombarded morning, noon and night, "Are you aware this man is tuberculous ?" Of course we are aware, but we cannot do anything about it. As soon as a patient is diagnosed we check up on his housing ; the health visitor calls, and then starts this bombardment of the housing office.

We are checked up very strictly by the L.C.C. They were most generous in early days in accepting almost every case for inclusion in their housing list, whether living on their housing estates or in the L.C.C. area, ex-Service people returning from work, men working in the L.C.C. area. If you could make a good case in those early years these people were rehoused. One by one these degrees of eligibility have had to go, and now we have to prove that it is a case of a positive sputum, that there are children in the house, and that there is desperate and dangerous over-crowding. They are, however, rehoused when they have passed all these tests.

The L.C.C. has excellent methods for checking on them. At periods they go through their lists and see that they are still live lists. They want to know if the patient still has got a positive sputum, and if he still has that number of children at home. But eventually our patients on the L.C.C. housing list are rehoused.

It is much more difficult in a comparatively small borough, and altogether it is a much slower process. I have myself a case list of 1,011 for 1951. I must have written 500 housing letters for different cases, but there were 225 cases that I considered, last year, were really desperate and, of that 225, 44 were rehoused. You can bring down that 225 to 94 really urgent cases, that is, positive sputum cases with children, and such overcrowding that life is absolutely intolerable for the patient and for the person who has to nurse the patient. It is very possible that there are certain areas, and properties, where it would be possible to nurse a tuberculous patient in one room. But you have to remember that in Tottenham, and places like it, we have inherited a terrible burden of housing, housing that was never fit to be lived in, and now, after 30, 40, 50 and 75 years, should not really house human beings.

We have every week half a dozen letters to the Area Medical Officer complaining of damp, of rotten plaster, of walls that crumble, of defective roofs. He sends out his sanitary inspectors, who bring pressure to bear on land-lords, but often much of this property is already condemned, and there is very little you can do with it. If you have a house, and you occupy one room upstairs, and your only access to the toilet or running water is downstairs in the house or room of another family, how can you nurse a tuberculous patient ? In many Tottenham houses the only toilet is in the backyard. How can anyone nurse an infectious disease under those conditions ?

So I think it is very difficult to get valid figures based on the number of people to the house, or the number of people to the room, because so much depends on the condition of the house, the situation of running water, of the lavatory, of air and space.

I shall be very interested to hear from Mr. Walls how his organisation proposes to safeguard the new houses that are going to be built, because if we are going to have perpetuation of the speculative builder all of us are at the mercy of what he can do to us, and the position is hopeless. If they build inferior houses in which people must go on living, family after family, decade after decade, the amount of misery and ill-health left for people like us to deal with is hopeless. Housing is the basis of life, and if housing has to be affected by rearmament the position will be even worse.

There is just one point on which I have done quite a lot of work lately. We do have certain applicants for rehousing who, with any sort of encouragement and protection, could supply their own housing. It is not an uncommon thing, but an extraordinary social phenomena, to find in a small house in Tottenham, with rent probably 15s. to £1 a week, that there might be one, two, three, four married couples each occupying a room in the house, using the kitchen communally, and every one of those rooms possibly represents earnings of from £10 to £15 a week. It is perfectly preposterous that those people cannot be encouraged to use that amount of money, not for gadgets, hire purchase, furniture, bicycles they have nowhere to keep, but towards providing a home for themselves. I have made some investigations on this matter. You apply for building licences, and you get nowhere. Building societies are more anxious to have a purchaser with a certain earning capacity ; they concern themselves much more with that than with the quality or the type of house that has got to be bought. Local authorities are almost as sticky as the building societies in this matter. Surely, if some protection could be given to these potential purchasers a lot of these people

would be removed from the housing list. Take an instance where the son or daughter is married and living at home with the parents—perhaps there are two sons and daughters—one of the parents contracts pulmonary tuberculosis, and has got a positive sputum, the people living in the house are a danger to their children. Their solution is either to be rehoused, or that we should remove the patient. Very often among these children you find a man who is earning £400 to £600 a year; at one time that man would not have lived on a housing estate for anything, now he has the idea firmly in his mind that he is going to be housed. I find them most unenthusiastic about undertaking this responsibility. It is terrifying to them. People, without a qualm, will embark on the hire purchase of a television set, or a horrible suite of furniture which costs them 150 guineas—which you know is only packing wood and veneer—but they cannot get it into their heads that it is better to embark on the purchase of a house. They are terrified of legal responsibilities and even of possession. If they could get the idea into their heads that now they are no longer the dispossessed, but that if they are skilled craftsmen they earn a decent wage, this thing would become a possibility to them.

I blame the local authorities because if these people go to see about these things they always come back depressed. They say, "They don't think I'm earning enough." Then you say, "But your wife is working." "Well, they won't accept my wife is working unless you give a medical certificate saying that she will not have any children"!

The National Assistance Board will cover the return of their interest in rates and taxes. The local authority at least has the house, it holds the deeds, and has security from that house. I cannot think why authorities are so timid about this. If you say, "Surely you will help to get the people off the housing list," they say, "That's nothing to do with us. We are only concerned with the advantage of the would-be purchaser."

I do not think we can ever hope to have a quarter of a million houses a year, but let us make it easier to have different approaches to this problem. Take requisitioned houses; some of them are in a shocking condition, and I cannot see why they are not made more liveable in. If I lived upstairs and had to go through someone's kitchen, where they shaved, washed, had a bath, cooked and everything, every time I wanted to use the lavatory, I would open the roof and drop a ladder down and do it that way. We must meet these things with a little more courage and initiative. The tuberculous must be housed, but I do not like the idea of their having an unfair share of houses. Already it is being said "This man has been away for major surgery, and he is no longer positive"; he has suffered a great deal in making himself negative, but he is removed from the housing list. Housing should be done for reason of infection, also surely for a preventive measure, and to keep these people well. After all, you have spent hundreds of pounds in sanatoria and hospitals to bring them to this healthy condition.

F. G. Brown, M.B., D.P.H. (*Medical Officer of Health, Wanstead and Woodford M.B., Area Medical Officer, Essex*):

I only knew that I was going to deputise for Dr. Alcock, of Burton-on-Trent, at very short notice, and I just wish to touch on one aspect of this subject, that is the question of tuberculosis as it affects large housing estates.

I work in Essex, just on the outskirts of London, and in my area there are three large L.C.C. estates on which there are many tuberculous persons. I have certain figures that might be of interest.

To deal with one estate. The population of this estate is 14,000, and the houses occupied are approximately 4,000. The first houses were occupied at the end of 1947, and the estate is now just filled up, so that there are 14,000 people there to-day. The total number of cases on the T.B. Register from that estate is 350. Of those 350 cases, only 50 have ever been sputum-positive since they have been resident on the estate. Of the remaining cases, very many have had a long period of sanatorium and hospital treatment, as a result of which the disease has become quiescent. Many others are non-pulmonary cases; they are surgical cases that have never been of an infectious nature.

I tried to discover how many new cases, other than those that have been rehoused on tuberculous grounds, had occurred on this estate. I know it is very early days, as the people have not been there very long, but I found eight cases, seven of which are sputum-positive cases. Over the whole estate, approximately one house in every 11 contains a notified case of tuberculosis, that is, a case that is on the Register. But this ratio has become higher among the more recent arrivals, and I should say among the more recent arrivals on this estate the ratio was about one to six or seven.

The real point I would like to make regarding these people is a financial one. It is a very considerable financial burden that is caused to them by the fact that they have to live outside London on these estates. First of all, the rents are approximately doubled; the average rent, I should say, is about 27s. 6d. to 32s. 6d. They were probably paying half that in London. Secondly, there are the fares. These people have to travel a long distance to work. Many of them have to pay 3s. or 4s. a day on fares. Thirdly, there is the evil of the hire-purchase system. These people have been living in London in very poor quarters, where they have had shabby old furniture. They move out to Essex, to these estates, and this old furniture shows up very badly among the new surroundings, and they are at the mercy of the hire-purchase system that is going round the estates the whole time trying to persuade them to buy rather elaborate furniture and television sets; and they do fall a prey to these people.

Now it seems to me that this is going to be reflected on their health; it is bound to be, owing to the financial strain they are suffering. I do not say a large number of them are breaking down, but it is occurring. This is a point very strongly to be borne in mind before people are rehoused on these estates a long way from their work. Can these people really afford it, or are conditions going to be such that it would have been better if they had not been sent there? Alternatively, can they not be rehoused in London or in the middle of the town where they can be put in flats that are near their work and will not entail the large travelling expenses to which they are now put?

Norman H. Walls (*Director of the National House-Builders Registration Council*):

I have listened with the greatest of interest to the other speakers, and the impression which I had previously formed that this Association is doing a very useful and a very necessary work has become a strong conviction. I feel myself something of an interloper in this company, because I have always been associated with the building side of your problem to-day, not with any aspect of the medical side. I share to the full the average layman's horror of the initials "T.B." I did not know whether this was a hereditary disease or one that was induced by bad housing. I learned earlier to-day that there are still many doubts as to where it comes from and why. Certainly it is one of these scourges that thrive upon bad living conditions, and what you are particularly considering to-day is how one could improve the housing conditions in the country to help you in your work of getting rid of the scourge of tuberculosis.

My principal concern is to try to ensure that all new houses that are built are put up to what are generally regarded nowadays as civilised standards. I have approached this subject as a local authority official, then later as a Government official, and more recently in my capacity as Director of the Housing Improvement Association under the National House-Builders Registration Council. In all of these capacities I have found that housing, good housing, is first and foremost an economic problem.

I hesitate to make any definite statement, but my own firm conviction is that, even with the high costs of building to-day, it is possible to build houses which could be sold,

or rented, to nine-tenths of the population without any subsidy. In other words, I think that we have become very subsidy conscious. We have come to the conclusion that we must look to the State to provide us with a house, and we forget that for many generations one-fifth of the family income was regarded as a reasonable allowance, a reasonable amount to pay for housing oneself ; and it should still be possible to house the bulk of the population to-day within one-fifth of the family income ; to house all except what we used to call the " submerged tenth."

Space standards in this country (I mean the number of rooms and their size) are higher than in any other country in the world. I am referring to the standards of the houses that were built before the last war, and after the first world war, and to the standards prescribed by what is known as the Dudley Committee. In more recent years we have rather extravagantly expanded these standards, to the detriment of the number of houses that we have been able to produce.

I am concerned more with structural standards than with space standards. Structural standards are at least as important as space standards. Yet, if one attempts economy, it is generally the structural standards that suffer. I do not want to quote what would be more appropriate to an architectural or a building audience, but there are many structural standards which can be safeguarded, such, for instance, as the provision of hollow walls in houses. A 9-inch solid wall should never be used in any circumstances in this country unless it is adequately waterproofed. An extra course of brickwork in the foundation to raise the house just 3½ inches higher than the water level is in many cases not an extravagance, but an expense that should certainly be indulged in. Drain-laying is a skilled operation which should receive the greatest care. The jointing of plumbing work, adequate ventilation of pipes, provision of decent accesses and so forth, is something that should not merely be left to the foreman on the job. Steps must be taken to avoid damp penetration. Dr. Chalke remarked that damp houses were more liable to foster the growth of tuberculosis than dry houses ; and I can well imagine it. But it is not altogether easy to assemble the building materials into a house and provide something that will be mathematically exact, like a motor car. As a matter of fact, there is much that needs to be done to keep the damp out of a house. Proper flashings must be connected at every junction point, doors and windows, where they pass through the walls, must be very well fitted in order that damp does not penetrate, and all of these things must be safeguarded on behalf of the person who is going to occupy the house. There are some provisions in by-laws that may be regarded as being outmoded. I have one in mind particularly ; that is the one which says that a habitable room without a fireplace must be provided with an air brick, the original intention being that that house should have an adequate means of ventilation. But in 99 cases out of 100, if you go into habitable rooms provided with air bricks you will find that the owner of the house has carefully papered it over, and it is not doing the job for which it was inserted. On the other hand, the very fact of putting that air brick into the wall has laid a possible track of damp through the wall, and its provision may be a worse thing than if it were omitted.

Good housing is a social service of the highest order, but to say that anything is a social service is not necessarily to say that it is something that must be provided by the State. I mentioned that my first association with housing was as a local authority official. The houses for which I was responsible when I was a very young man were houses in your city, Sir, Edinburgh. They were known as improvement schemes, and they were improvement schemes at least to this extent, that they represented a very great improvement on the houses that they replaced. They were built under some very old legislation of 1870 or thereabouts, and they were situated, unfortunately—they were sometimes new houses, sometimes re-built—in slum areas, and possibly because of that they were tenanted by slum tenants. While some of these families were very decent people, the majority of them were not. The rents were always in arrears, but they generally had sufficient on the Saturday night to get so tight that when they went home they pulled off the chain and ball from the lavatory and bundled it down the basin, and it was quite a usual thing to have half a dozen plumbers going out on the Monday morning to make good the ravages of the Saturday night binge. That, I may say, was 40 years ago.

After leaving the Edinburgh Corporation's service I went to the Local Government Board, where I expanded my interests from housing to town planning. The first town planning was placed on the Statute Book in 1909, and about 1914 we thought we knew all there was to know about town planning. But we were only then beginning to know how much we did not know. At the same time there was a Royal Commission on Housing in Scotland, and I remember taking a lot of evidence from tenements in Glasgow and Greenock and being closely associated with some of the worst housing conditions that I have known anywhere.

We also built a number of schemes, 20 houses, 100 houses, in the case of Rosyth 1,000 houses, all of these built before the first war.

After that war we advised the local authorities in Scotland how to tackle the housing problem that then faced the country. It was very largely a local authority problem ; there was very little private building at that time. Most of the local authorities built through the agency of contractors, although direct labour was employed. I mention that only in order to avoid being implicated in the political aspects of housing ; one of the things that has bedevilled good housing in this country is the fact that it has become a political problem. We gained a lot of experience at that time and found an awful lot that needed doing in the way of educative propaganda, both for town councils and for the person who was going to occupy the house, for the builder and for the public. Among the jobs that we found it was very necessary to do in those days was to find better descriptions for the work that had to be done, standard specifications which would enable a really good material to be available cheaply and always to be available if the standard specification number was quoted. It was not to be left merely to the descriptions which were current in those old days ; there were new conditions of measuring building work and standard forms of contract to make things more equitable and to make the prices of houses more fair. In doing all these things it was necessary that the whole industry should become very much better organised. When I say " the whole industry " I mean the trade unions ; they grew in strength and in the service which they rendered tremendously. So did the employers' organisations, so did the professional institutions of architects and surveyors. While they were growing, they were putting themselves in the position to render much more service to the industry and to the community and, incidentally, to the cause of house building.

I want to repeat that, however you may approach the subject of housing, sooner or later you are brought back to the fact that it is a question of £ s. d. You gentlemen approach it from a health and a medical aspect ; there are many who approach it from a political aspect, but whichever way you approach it you cannot get more than a pint out of a pint pot. You find sooner or later you are asking yourself, " How can we get the best value for a pound's worth of expenditure ? " However, you must set yourself a target of 300,000 houses at £1,000 each, if you can get them, and if the houses go up to £1,500 each you either have to be content with 200,000 houses, or you must somehow or other look for economies, and the housing standards are liable to suffer. They are suffering in many ways, but particularly if housing is to be a State service, and the extra cost is to come out of the local authority or government funds. The person who occupies the house has no real idea what the actual costs are. We know that there is a Government subsidy of £16 10s. and a local authority

subsidy of £5 10s., we know that that is very often insufficient, and that the local authority has to dip into its pocket for further sums to make ends meet, but the person who goes into the house merely knows that the rent is Xs. per week, and in the modern language "they couldn't care less."

The person who buys a house does have an idea what the ultimate cost is, because there is no subsidy for such a person, and, faced with the cost of repairs, he very often finds that it is an economy and convenience to do the repairs himself. Certainly, looking after his own property, he is more careful than if there is a good government or a good local authority to come along and keep the house in repair for him. I mention that matter, because the Institution of Municipal Accountants and Treasurers have been recently greatly concerned at the fact that in their earlier estimates not sufficient money had been included to keep these houses in good repair, therefore the time will be coming when either subsidies must be increased or rents must go up, or the houses will suffer for lack of repair.

I should like to answer the point raised by earlier speakers, as to how housing standards could be improved and safeguarded. It is a condition attached to every licence issued to-day that the standard must be equal to those prescribed by the National Housebuilders' Registration Council, the body of which I am Director, and they must be subjected to at least the same degree of inspection as would happen if the certificate of that body was obtained. It would be absolutely impossible to say that every house had to be submitted for inspection. There is a large occupation of architects in this country who build houses, and it is certainly not one of our purposes to put architects out of a job ; we think they should design and assist and see that the houses are well built. But otherwise the houses should be submitted for inspection. The Registration Council itself represents 20 different organisations, all with some housing interest, not only the builders and the operatives, the building societies and the owner-occupiers, but urban district councils, rural district councils, municipal engineers, medical officers and others. It is a very big representative council, and the specification which it has prepared has received the general approval of all the bodies represented on the Council. It inspects a house at least five times during construction.

That, I think, is the answer to anyone who asks, how can the nefarious activities of the jerry builder be prevented in future ? See that the house is, in fact, inspected by the Registration Council.

If I were asked to make any real, solid contribution to this debate, I think it would be to say, build more houses. Most of your troubles must arise from the 4,000,000 houses that Mr. Greenwood told us are now over 100 years old, and then a great deal must arise from the houses that were built before 1914. Generally speaking, our standards over the last 30 years have been inconceivably better than they were in the last century.

I hope there will never be a ceiling for the standards of housing in this country. But, as your troubles and difficulties come mostly from overcrowding in small houses that are very old, the answer seems to be to build more and more houses to-day, get so many houses built that there will be sufficient surplus to enable you gentlemen in the exercise of the Sanitary Acts which you administer to close down those old ones that are really a menace to the community.

Discussion

Dr. James Cuthbert (Chest Physician, Leicester) : The opening speakers have covered the subject very fully, and left very little for me to say on it. I see the problem from a chest physician's viewpoint, but it occurs to me that there are three other viewpoints, namely, those of the medical officer of health, the patient and the housing committee.

When I have a case of tuberculosis notified to me my health visitor, as you are aware, makes a complete environmental report which includes particulars of the patient's housing conditions. We do everything possible to rearrange accommodation in the afflicted household so that the case can have a bed and room to him- or herself. This often necessitates moving a bed downstairs to a front room, lending a bed or bedding to the householder, or arranging for children to sleep with relatives or foster parents.

In Leicester we advise rehousing (*a*) if the case is infectious, or (*b*) if rehousing will help the cure of the patient in the absence of infectivity. But the cases recommended must either be in overcrowded houses or in lodgings.

Now in the past two years our recommendations for rehousing to the appropriate authority number 179. How many of those were actually rehoused ? Well, in the year November, 1950, to November, 1951, 100 special tuberculosis cases were approved, but only 67 cases are actually in new houses for that period. Of the 100 cases approved, 28 were full tenants and 22 in lodgings. You see there are difficulties even when the housing committee recommends rehousing. For most of the 33 applicants not yet rehoused there are simply no houses available at the present. It may be that only post-war houses are available. If so the rent will be 23s. 9d. per week for a new three-bedroomed council house, or 27s. 1d. for a new four-bedroomed house. Many patients cannot afford even this, and in that event there is delay in rehousing, because the applicant's name now goes on the urgent waiting list as a case for a pre-war house at a rent of 11s. 8d. or 14s. 5d., or a pre-fabricated house at 14s. 1½d. per week. Other reasons why cases cannot accept houses allotted to them are that they may refuse because the new district will be too far away from relatives or from their work.

In some cases the Council will find it difficult to house small families at once when only large houses with four or five rooms may be available at the time.

From my point of view, while I would like to see more of my patients rehoused, I do know that in Leicester at any rate my recommendations are being seriously considered, and that the patients are getting a fair share of the available number of houses.

The Medical Officer of Health has his point of view. He sees the overcrowding problem as a whole, which is very important, the slum clearance to be done, and the overcrowding on the sex ratio, which has an important moral aspect. People requiring rehousing on those grounds far outnumber the tuberculosis cases. It is surprising how often beds can be re-arranged in the house to give a tuberculosis case a room to himself.

In Leicester the Medical Officer of Health is personally concerned with each case who applies for rehousing on medical grounds. I submit a report to him on the circumstances and infectivity of the tuberculous cases for whom rehousing is advised, and I may say that very few of the non-tuberculous cases are rehoused on medical grounds.

Then there is the patient's viewpoint. It has become almost the accepted thing for a family to apply for rehousing when tuberculosis is diagnosed in a household, and I do not blame them for trying. However, chest physicians must be fair, and for that reason must stick to the rigid criteria of infectivity of the case, of overcrowding, or living in lodgings, as grounds for recommending rehousing.

I constantly see cases who report to me, with a doctor's note, complaining of chest symptoms. Time is spent on *x*-ray and clinical examinations, and no lung lesions are discovered. A few weeks later I am informed by the Medical Officer of Health that the patient has applied for rehousing on the grounds of attending the chest clinic with pulmonary tuberculosis !

This happens not once but time and again. Some of the more innocent ones hint, at the medical examination, that housing conditions are poor, and ask if we can help them.

Finally, we have the point of view of the housing architect and his committee, and there the hard core of the problem lies. Let me give you some figures for the city of Leicester which, I consider, is typical of the Midlands. They bear out some of the points Mrs. Nicholson has already stressed. From the end of 1945 to December, 1951—that is a six-year period—the housing department had a total of 13,539 available houses to let, and an analysis of these shows that there were 9,000 pre-war houses, 3,966 post-war houses, and 573 pre-fabricated houses. Now the present list of housing applicants numbers 15,000. Of those, 11,000 live in rooms ; the remaining 4,000 are in unsatisfactory houses. That is to say, because of sex, overcrowding, or defective sanitation ; many of those latter houses being the older type of two-bedroomed house.

Last year 1,216 houses were let by the local authority on the average of 23 per week, and all those were post-war houses, 674 of them being brick built, and 542 being concrete houses.

Now I have already mentioned the difficulties in trying to find houses at a rent which the applicant can afford. There is no solution to the problem unless we get more houses. Contrary to what Mr. Walls has said, in authoritative circles in Leicester

it is generally understood that even if we had the money, the material and the land, etc., so that we could go ahead, there is not the labour available at present to build more of the traditional brick type of house than we are having. The number could be increased somewhat with non-traditional types of houses such as concrete and other pre-fabricated houses, other than steel houses. The housing architects' problem, then, is the largest one, and looking at the picture as a whole I can see how only 67 of my tuberculous patients were rehoused in 1950–51. It is evident that we shall have to go all out for the non-traditional types of houses to solve the present crisis.

In the ensuing discussion I should like to hear the views of the members present on how far chest physicians should go in recommending rehousing; should they have strict criteria for rehousing recommendations, as I have, or should they take a more lenient view, as they do in some cities? I have in the clinic tuberculosis register of 2,030 names, 775 chronic open cases of pulmonary tuberculosis. If their housing conditions are adequate, I can keep them at home, thus saving a bed in a sanatorium for an early treatable case. You see, the various problems of the chronic sick patient, the nursing and the hospital bed shortage, and the housing shortage are all interwoven. I must confess, I am not so worried about the chronic case of tuberculosis who has a family at his back as about the single person to whom it would be folly to allocate a large house. Those single persons usually end up by blocking a bed in the chest hospital; the actual figure for our chest hospital in Leicester is that 22% of the cases at the moment are chronic untreatable cases, blocking beds. If we provide hostels or night sanatoria for them, all sorts of bad habits may be formed, and the little communities may well go sour, to quote a recent editorial in the journal *Tubercle*. Those are often social problems, those single cases, apart from the tuberculosis.

Village settlements are not the answer, as many of the cases are unsuitable for entry. My own view is that the best-known way of solving the problem in those single cases is to re-open a ward for the tuberculous in our larger general hospitals on the lines of the wards that used to exist in the old Poor Law institutions. A variation of this would be to use empty wards in some of our existing sanatoria, but the drawback to this, however, is that the single chronic case with his bad habits would upset the rhythm of the rest of the hospital.

I have been thinking on an idea for some time, which would be to allocate council houses to childless couples, the incentive or condition being that they will take in as a lodger one of our homeless chronic cases of tuberculosis. I think that in some cases the idea could be developed and made to work with a little education and subsidising and co-operation all round. I am looking forward to hearing the members' views on rehousing the tuberculous at the subsequent discussion.

It is true that we do not know enough about the disease, and how it arises, as Dr. Chalke has said. You may be aware that there are theories of infectivity, endogenous or exogenous theories of infection. If we believe in an endogenous theory of infection, then there are very few grounds at all for advising rehousing in the case of tuberculous patients, unless everybody in the country were to receive B.C.G., because without that universal B.C.G., the danger in the home has already been done long before the case comes to our notice.

Dr. J. Greenwood Wilson (M.O.H., Cardiff C.B.): I would like first of all to congratulate the organisers of the meeting on the very fine symposium of opening addresses which they arranged for us. We had this statement of the housing need; we had the epidemiological aspect from Dr. Chalke; we had a brilliant exposition of the social aspect from Mrs. Nicholson; we had again the social aspect from Dr. Brown, and the very important viewpoint of the building industry, of the technicalities of it, from Mr. Norman Walls.

We have had from this symposium, and the remarks from Dr. Cuthbert that followed, a great summing up and clarification of the problems that face us. I would only like to put myself on the side of those who warn us to be careful to treat each case as an individual case. It is true that there may be danger of abuse; we have had a tuberculous tenant, and mothers with young families have deliberately gone as sub-tenants, knowing that thereby they would quickly be rehoused.

Regarding Dr. Chalke's point, however, I do not think they did actually gain infection; perhaps they were not there long enough. My main contribution is to suggest that we must think of this housing question as a part of the whole rehabilitation aspect of the tuberculous. It is not any good rehousing them where they are going to spend all their money on bus fares, and so on. At the same time as getting them a house you have got to get them a job. You have got to see that they get enough food and clothing. You have got to look after all the aspects of home treatment. Housing is one aspect of the total rehabilitation problem, the care and after care of every tuberculous family should be faced from that point of view.

Dr. W. H. Bradley (Ministry of Health): My own special interest in tuberculosis is that of a general epidemiologist, and when it comes down to trying to think of one of the numerous factors which are concerned in its spread, I begin to get into difficulties. But I am not in quite such difficulties as Mr. Walls. He would, perhaps, be seriously misled if he felt that the doctors here had any real doubt about the cause of tuberculosis. We are doubtful about some of the details in relation to the way which tuberculosis goes around.

That brings me to one point which has disturbed many of us in our thoughts about rehousing in tuberculosis: the work of Webb and Alice Stewart, of the Oxford Institute, working on the new housing estate at Northampton. If in fact the velocity of the spread of tuberculosis is increased by moving persons from one place to another, we have got to look at it all very carefully indeed.

Whenever I go to a part of the country and look at their tuberculosis problems I find that there is something just a little bit different about every place. Not long ago I was in the St. Just peninsula near Land's End. There is a particularly serious problem of tuberculosis in relation to the tin mine there. One finds the old tradition, Cornish cottages in blocks close to the tin mine, housing families where there has been a history of tuberculosis for 25 to 30 years, or sometimes 50 or 60 years, sometimes three or four generations. If one begins to move those people out to more convenient housing, one leaves on those sites the healthy people who are still able to work; or, what is more likely, one finds that unless the local authority is very vigilant, somebody with a little more money comes along and, with the expense of really relatively little these days, manages to convert a Cornish cottage on a cliff into a very nice week-end cottage. It would not be very difficult on some occasions to adapt that house, make more space, overcome the overcrowding and move, perhaps, the adjacent families. Rehouse the healthy rather than rehouse the tuberculous. I know how difficult it is for any of us to decide whether we shall rehouse at the expense of the tuberculous, or rehouse at the expense of the community.

However, in this discussion one must not lose sight of the fact that the good old principle of "find, isolate and educate" is the principle we all really hark back to in the control of tuberculosis. We have had a very great stimulus to return to that view, and always have it in the forefront of our minds in the work that has been going on in Minnesota recently, where, by treating their tuberculosis as a problem of a relatively acute communicable disease in slow motion, they have had the most remarkable results. We do not want to put too much of our money into this problem of rehousing the tuberculous. We must not let it divert us from attention to other ways of dealing with tuberculosis.

Dr. J. Stevenson Logan (M.O.H., Southend C.B.): Speakers have stressed the necessity of looking at the claims of the tuberculous as individuals. I do not see how we can do our job unless we, who advise the housing committees, are personally advised by the tuberculosis physician. In our own department we have a weekly meeting which is attended by my physician for tuberculosis who is with me this afternoon, the Superintendent Health Visitor, the Senior Sanitary Inspector and the case workers in the department. These applications for rehousing are put up there, and it is surprising how often, by the time we have pooled what we know about the case, we come to rather a different conclusion than we might otherwise have done. This has two very great uses; first of all, it makes the best use of our very limited houses. The second thing it does is to enable the field worker to go back without such a great sense of frustration, because very often for the health visitors and other people there is the case which really is a stone wall, and might even look a stone wall from the clinician's point of view, but, when all the available knowledge is pooled, people go away, even when their cases have not got the priority they thought they were going to get, rather better satisfied because we are working together as a team. It is terribly important in the growing complexity of our organisation that the field worker should know that the case is adequately presented and discussed, and that they should know what you have done about it.

Dr. J. C. Sleigh (M.O.H., St. Albans M.B.): In all cases where a medical certificate is produced as an additional reason for housing, these medical certificates are sent to me, and I assess the need on medical grounds. I allocate additional points, I do not recommend them, there is no argument in front of a committee or anything else. A committee is not a place, in my opinion, for the relative importance of tuberculosis, or venereal disease, or of rheumatoid arthritis to be discussed; the only person who can give a proper and fair estimate of that is the

Medical Officer of Health, who cannot be got at by interested persons.

In my area, I can allocate at present roughly about one-quarter of the total points required to get a house. In addition, I can allocate about another quarter on the grounds of overcrowding, or bad housing conditions, dampness and so on, so that gives one a very heavy lead as to who is going to get a house.

Finally, you all come across these cases where no points scheme in the world will quite meet a really urgent case. For these cases I have the power to allocate a house, completely ignoring the points scheme from beginning to end. That is a very big power to place in the hands of the Medical Officer of Health, but I believe it is working well, and I believe he is the only person who can properly be given that power. Needless to say, that power of absolute priority in allocating a house must be used very, very cautiously. In the last 10 years I think I have used it six times, curiously enough twice inside a fortnight, with the same local authority. But that does happen and you have got to put up with it. You are there to be shot at!

Dr. J. R. Mikhail (Chest Physician, Bournemouth): Hart and Wright wrote a very good article on the housing of tuberculous families, I think in 1939; they found that one of the most difficult problems, and I think a lot of us have found it a difficult problem, is the tuberculous family which needs rehousing, and, although the local authority are willing to rehouse them, owing to the fact that they have been taken ill with tuberculosis they cannot accept the higher rent without some deterioration in the calory intake in that family. Surely one of the most difficult problems is how to deal with the patient who cannot afford the higher rent of being rehoused on the council estate without at the same time going short of food. That problem is one that needs to be urgently tackled, and some form, perhaps, of rent subsidy in selected cases might be of very substantial help.

Dr. C. G. K. Thompson (M.O.H., Wakefield C.B.): I would like to add some facts on a scheme which was started in 1926 in Wakefield, when special houses were built for tuberculous persons. I have on my register 221 tuberculous persons for a population of 61,000. These houses are of a three-bedroomed type, the biggest of which includes a veranda just large enough to take a single bed and a small bedside table. This veranda closes off from the rest of the bedroom by a folding screen. The rent is 15s. 3d. per week. These houses are let to any tuberculous patient, but preferably to an ex-sanatorium patient on the recommendation of the Chest Physician. The Medical Officer of Health, however, has entire control of the letting. Families are rehoused when the patient's disease is either arrested or cured, again on the recommendation of the Chest Physician.

One hundred and twenty families have occupied these houses since they were opened in 1926, that is, roughly five families have been in each house during those twenty-five years. The average stay is five years, but because pre-war they were occupied anything up to 10 years they are more likely now to be occupied for about two years, as patients are moved when their disease is arrested. The house is visited every three months by the Sanitary Inspector, every month by the Health Visitor. Each house is disinfected and fumigated about every four years. On the average, the percentage of cases that can be rehoused is 10. We have a rent subsistence scheme of about 3s. to the full rent.

Dr. A. E. Brown (M.O.H., Diss, Norfolk): We have heard a great deal about the need for new houses and the economic basis of the trouble, but surely we have got many more houses in operation now, not pre-war houses, which we therefore must keep in repair. I belong to a rural district where I see quite definitely a much more rapid deterioration in the older houses than need be the case if owners were in a position to put these houses into and keep them in decent repair, and keep them habitable. Now, I know that only about a quarter of the population of the country lives in rural areas, but in these areas it is common practice for cottages and small houses still to be let at a rent of a few shillings a week. Rents which might at one time have been fairly economic now produce a return from which no owner can keep his houses in repair at all, and these houses are going to be lost to the community a lot sooner than they ought to be. I have tried on several occasions to operate the Public Health Act and the Housing Act, and to get these properties brought into some state of good repair, to get dampness dealt with and so on, but I find when I get down to it that we cannot expect an owner to spend £150 on a house for which his net return is something of the order of 2s. or 3s. a week, and that I am therefore faced with the position of saying that that house is incapable of being made fit at a reasonable cost.

The basis of this trouble, of course, is the Rent Restrictions Act. I know that this is a political bogy, but even if it is, we have to face up to the fact that often there are houses which could be made fit and are not because of the operation of this Act, temporary legislation which hits right at the fundamentals and interferes with the working of decent public health legislation which has grown up carefully over 100 years.

I would not like Mr. Walls to go away from the meeting feeling that at least I could agree with him on one point; he mentioned that a fifth of his income was a reasonable amount to expect a person to pay for rent. I cannot agree with that figure. In these days, I think we must admit that a certain number of outside pleasures, cinemas and so on, are no longer luxuries, they are almost the necessities of life, and I feel myself that a seventh, anyway, is the figure which we should aim at.

Nobody has mentioned so far the case of the person who is higher up the social scale, the person who is already in a job earning £700 or £800 a year and gets tuberculosis. Now, what about the effect on that person's family life of getting that disease, the fact that he has to go into a sanatorium for a while? He gets certain grants, but his standard of living falls very greatly and that of his family, and he comes out often with a much prejudiced future. This case of a man who has had a rather better start in life, who is a little bit better off, who would have rather a better future, needs much more financial assistance than it gets at the moment.

In the council house rents the 8s. subsidy which district councils get for their building is usually handed on willy-nilly; it certainly is in my area. Yet, as we have heard from other speakers, there are often council houses where there is a very considerable amount of money coming into the house, there is more than one wage-earner, and I wonder whether it is right that this basic housing subsidy should be handed on willy-nilly like this, and whether we could not use these 8s. subsidies on each house, which come to a very substantial sum, to subsidise people who really do need it, and subsidise them much more effectively than they are at the moment. I have had some difficulty with getting my Housing Committee to see this point. They agree in principle, but they feel that it would be a political folly to put it into practice.

Dr. E. G. Sita Lumsden (Chest Physician, Southend-on-Sea): May I, as a Chest Physician, enter a short plea that we should not take too much notice of the findings at Northampton, nor let it in any way diminish our drive for rehousing tuberculous patients for fear of contact spread. Of course, the Northampton investigation referred to a very congested, overcrowded area with poor housing, and there are other explanations than that the tuberculosis spread from house to house. I think they are, first, that nearly all the persons in those houses worked at the same type of work, almost in the same factories. Secondly, as we all know, those who work at the same work tend to live in the same part of the town. Thirdly, of course, they have the same sort of economic level. Therefore I think you must not let this investigation in Northampton in any way diminish our drive to rehouse our patients.

The Chairman: I think you will all agree with me that no person could summarise this discussion to-day. I will confess that I can imagine Chalmers of Glasgow looking down on us, and guiding us perhaps. Dr. Harley Williams tells me that we will have available all the words of wisdom that have been given us to-day, so that we will have an opportunity of studying them carefully and in our respective spheres perhaps coming to some conclusion. I would confess that I as an individual have come to one conclusion, that I have got to go back to my home area and study this problem minutely and carefully. I agree with you, I was very worried about the Northampton experiments, and I satisfied myself that they certainly did not apply to the City of Edinburgh, and if they were applicable to the whole country I am satisfied that they would do us an enormous amount of harm. I am reminded of A. K. Chalmers, who used to say to us that the more the people who live under the common roof the sooner they die.

I would like to thank you all very much for taking part in this discussion, but may I chiefly thank our principal speakers, who introduced the discussion. I would like to say, Dr. Harley Williams, that I think this joint meeting of ours has been extraordinarily successful; it will have gingered some of us up very much to try to get accurate answers to many of the questions that we have put to ourselves to-day.

County District Group Annual Meeting

We regret that by error the day of this meeting was wrongly given in our March issue. It will be held at the St. George's Hotel, Margate, on *Tuesday, April 22nd*, at 8.15 p.m.

OBITUARY

CHARLES KILLICK MILLARD, M.D., C.M., D.SC. (P.H.), EDIN.

We record with great regret the death on March 7th in his 82nd year of Dr. C. Killick Millard, Medical Officer of Health for the City of Leicester from 1901 to 1935 and President of the Society for the session 1931-32.

Dr. Millard was born in August, 1870, the son of a Nottinghamshire rector, and was educated at Trent College and Edinburgh University. He graduated M.B. in 1892 and took the B.Sc. (P.H.) in the following year. After a resident appointment at Birmingham Fever Hospital, where he made his first encounter with smallpox in 1893, he was promoted Medical Superintendent in 1896. In 1899 he was appointed M.O.H., Burton-on-Trent, and three years later of Leicester, where he served until his retirement, though during the recent war and after he returned to active work as M.O.H. for the Blaby and Lutterworth rural districts, which he gave up only last year.

It was in 1903, when smallpox caused 406 cases in Leicester with 21 deaths, that Millard first showed his special approach to the subject of vaccination on which he acted throughout his career as a sort of George Bernard Shaw among his public health contemporaries, causing them to think furiously even if they did not always agree with him. Leicester had for many years been opposed to compulsory infant vaccination and *The Lancet* had sent a special commission as long ago as 1886 to investigate the city's method for controlling smallpox. Medical officers of health have long agreed with Millard that mass vaccination at the time of an epidemic is no way to control the infection once it has arrived, but they would not even now accept his advocacy of the abolition of infant vaccination as the best method of achieving a high national level of immunity. He published his views in book form in 1914 under the title "The Vaccination Question in the Light of Modern Experience" and was writing on the subject thereafter, witness his letter to the editor of this journal last September (*Public Health*, October, 1951, p. 13) when he commented on the Society's statement of policy last year.

He was a pioneer on another controversial subject, that of euthanasia, and made this the topic of his Presidential Address to the Society in October, 1931 (see *Public Health*, November, 1931, **45**, 39). Here he enlisted the support of many prominent men in medicine and surgery, notably the late Lord Moynihan, who became the first President of the Voluntary Euthanasia Society, which Millard served as Hon. Secretary until his death.

Millard was a remarkable man on any count and learned to fly at the age of 62. He bought himself a new motor bicycle for his 80th birthday and rode it to Inverness and back. Personally he was the acme of courtesy and was much liked by all who knew him.

We are indebted to Dr. E. B. Berenice Humphreys (M. & C.W., M.O., Leicester) for the following personal appreciation of her old chief:—

"The death of Dr. C. Killick Millard recalls to my mind many pleasant memories of an association which extended over a period of some 22 years. He was a national figure in the world of public health. He startled the daily newspapers with his Presidential Address to the Society of Medical Officers of Health by his views on Voluntary Euthanasia while at the same time preparing for his local health committee a detailed report on the overcrowding in his city, illustrating his notes with actual photographs of families of 8 and 10 persons living in one room and enunciating a theory—at that time unorthodox—of differential rents as essential in any scheme of rehousing. He always contended that a new house alone would not suffice for these large families, unused to the amenities which would then be afforded to them. To many of them he was a constant and welcome visitor in their new surroundings; he it was who helped them to plan and to stock their new gardens. His car was often laden with plants, sacks of seed potatoes which he himself had raised for them. His garden was his greatest hobby and all of us in the health department shared his joy in the beautiful flowers he brought for us almost each morning. We also remember the generous hospitality he and his gracious wife afforded to each and every member of the staff.

"Fortunately for us, he remained on in his home at The Gilroes after he retired and so could spend more time working in his beloved garden. To the end he continued to share with us the fruits and flowers and the honey that his garden provided.

"His very strict ethical sense forbade him to enter into any discussion on the work of the Health Department after he had retired but his interest in public health remained undiminished. His work as a District M.O.H. in the county of Leicester kept him actively in touch with preventive medicine and he was a regular attender at the monthly meetings of the East Midlands Branch of the Society at Nottingham. It was my privilege to drive him to these meetings, usually along a route in Leicestershire which was very familiar to him and recalled the scenes of his upbringing in a country rectory. How he revelled in the ease and speed of the modern motor-car as compared with the penny farthing bicycle of his youth. He loved the countryside in every season of the year.

"Last autumn he wrote me a note to say he was afraid that unless his health improved he would not be able to make these monthly journeys but that they would remain with him as very pleasant memories. Reluctantly at last he resigned himself to an indoor life and the novelty of his television set. But in the last weeks of his long and active life he came to cease to look back upon that life. Rather did he contemplate with faith and trust the unknown life that was to follow."

Dr. Millard leaves two sons (one of whom is a general practitioner in Leicester) and two married daughters, to whom we extend our sympathy in their loss.

MARGARET SCOTT DICKSON, M.B., CH.B. (EDIN.), D.P.H.

We record with regret the death on January 29th at Dundee of Dr. Margaret Scott Dickson, formerly Medical Officer for maternity and child welfare in that city. She graduated at Edinburgh University in 1902 and joined the staff of Dundee Health Department in 1917. In 1925 she was appointed assistant lecturer in public health at Dundee University College. She remained in the service of Dundee Corporation until her retirement in 1942. She had been a representative to the Council of the Scottish Episcopal Church and a member of its social service board, and was a Fellow of the Society from 1930 until her retirement.

HERBERT GEORGE MURDOCH HENRY, M.D. (LOND.), M.B., CH.B. (SHEFF.)

The death occurred on February 1st, at Macduff, of Dr. H. G. M. Henry, well known in the Public Health Service for many years as the first city bacteriologist of Birmingham. Dr. Henry qualified at Sheffield in 1908 and took the M.D. (London) in the same year. After service in the R.A.M.C. in the first world war he was appointed to take charge of the bacteriological laboratory at Birmingham, where he continued until his retirement to Macduff, Banffshire, in 1948. He became a Fellow of the Society in 1920 and was a regular attendant at Midland Branch meetings.

SOCIETY OF MEDICAL OFFICERS OF HEALTH

EAST ANGLIAN BRANCH

President: Dr. R. A. Leader (M.O.H., Ipswich C.B.).

Hon. Secretary: Dr. A. J. Rae (Dep. C.M.O., West Suffolk).

A meeting of the Branch was held at Thetford on Saturday, February 9th, 1952, at 3 p.m. The President was in the chair and 14 members were present. Unfortunately the snow prevented several members from attending.

Dr. T. Ruddock-West, the County Medical Officer for Norfolk, had kindly arranged for the meeting to be held at the new Area Health Office, Thetford, and before the meeting and after tea members were shown round the building by Dr. R. N. C. McCurdy, the Area Medical Officer. The house, in a side street just off the centre of the town, has been adapted to provide, on the ground floor, an Infant Welfare Clinic waiting hall, perambulator shelter and sanitary accommodation, a weighing room, medical officers' room; two rooms for offices, a kitchenette and store. On the first floor there is a dental unit comprising a surgery communicating with a recovery room, a waiting room and a dental workshop: all of which, unfortunately, are unused owing to the shortage of dental staff; rooms for welfare officers and public health nurses, and sanitary accommodation.

The Fever Hospital

Dr. Grant, Medical Officer of Health for the County Borough of Great Yarmouth and Medical Superintendent of the Great Yarmouth Fever Hospital, gave a talk on "The Fever Hospital." He gave the members much food for thought and indicated ways in which answers might be found to many of the questions which are at present perturbing members of the Public Health Service. Dr. Grant discussed the subject mainly from the point of view of the medium-sized hospital serving a population of about 100,000, and took it for granted that the very small, ill-equipped and badly staffed hospitals were doomed. He reminded the audience that the admission of patients to isolation hospitals did not prevent the spread of disease and suggested that the primary purpose of these hospitals should now be the treatment of any feverish illnesses, whether infectious or not. He did not share in the clamour for the return of the fever hospitals to the local authorities and pointed out that they had gained much by becoming part of the general hospital service. Specialists could be consulted freely when required, the full equipment of general hospitals is available on demand, their dispensaries provided drugs which are only used occasionally, physiotherapists, etc., are available for poliomyelitis cases and the medical superintendent is relieved of responsibility for the day-to-day non-medical duties at the hospital.

Dr. Grant was not convinced that fever hospitals were redundant and, in this connection, he reminded the meeting of the growing encroachment of virus diseases upon human organism as well as the known fluctuation in virulence of the bacterial diseases. He did not agree that a close link between the fever hospital and the preventive service had been found to be necessary, and he put forward a suggestion that these hospitals should remain under the Regional Hospital Boards, but that the medium-sized hospitals, at least, should be staffed by medical officers employed on other duties in Public Health Departments. This would be advisable from the point of view of economy as the time spent, for example, on school medical inspections could be greater at the time when the hospital was not busy. It was not good for a doctor to be cut off entirely from clinical medicine, the continued practice of which enabled him to speak with his colleagues in general practice in their own language and would, Dr. Grant thought, increase his prestige in the lay mind. Humanity would always pay more "regard to the doctor who cures the pain in his belly than to one who may prevent a pain in someone else's." With regard to the suggestion that the fever wards should become part of general hospitals, he was somewhat sceptical. He doubted whether it would be a good thing for the nurse from scarlet fever wards to be in intimate contact with maternity nurses in their off-duty periods or for the nurses to be moved from wards where there were poliomyelitis cases to tonsillectomy wards as freely as might happen if the fever blocks were not a separate entity.

In the discussion which followed attention was called to the regrettable fact that recent entrants to the Public Health Service had not always held appointments in fever hospitals, and the value of acquiring such experience and keeping it up to date by continued contact with fever hospitals was stressed. Some members thought Dr. Grant had exaggerated the danger of cross-infection that might result if fever wards became part of general hospitals, and that this was the only way to ensure that nurses were used to the best advantage.

A hearty vote of thanks to Dr. Grant for his stimulating address was proposed by Dr. R. Gordon Drummond, of the Isle of Ely.

METROPOLITAN BRANCH

President: Dr. W. H. Bradley (Sen. M.O., Ministry of Health).
Hon. Secretary: Dr. F. M. Day (M.O.H., Hammersmith Met. B.).

Entries are invited for the "Metropolitan Branch Essay Prize," instituted by the Branch Council at their last meeting. The conditions attaching to the prize are as under:—

1. That a prize of £10 be offered out of the Branch funds for an essay on any subject connected with the practice of Preventive Medicine.
2. That the prize be known as the "Metropolitan Branch Essay Prize."
3. That any member of the Branch, not being a Medical Officer of Health, who has been qualified as a medical practitioner for a period not exceeding 12 years be eligible to submit an entry.
4. That each entry be made under a *nom-de-plume* and be between 3,000 and 5,000 words in length.
5. That the entries be judged by the President, the Vice-Presidents and the Hon. Secretary, and that the judges be empowered to withhold an award if, in their opinion, no entry of sufficient merit is submitted.
6. That the closing date for the competition be September 30th.

Any question regarding the eligibility of a member to submit an entry should be referred to the Hon. Secretary.

MIDLAND BRANCH

President: Dr. Colin Starkie (M.O.H., Kidderminster M.B.: A.C.M.O., Worcestershire).

Hon. Secretary: Dr. M. Alcock (M.O.H., Burton-on-Trent C.B.).

The third meeting of the session was held at Lancaster Street Welfare Centre, Birmingham, on Thursday, December 6th, 1951, at 3 p.m. The President was in the chair and 27 members attended.

The Hon. Treasurer, Dr. A. J. B. Griffin, presented his annual report and balance sheet for the session 1950-51, which were approved.

W.H.O. and Maternity Services

Dr. Jean Mackintosh then gave an address on the above. She gave a most interesting account of her experience as one of the joint secretaries to a committee dealing with maternity care, upon which a report will shortly be published. The main objective of the organisation is the highest possible attainment of health for all nations. Seventy-eight countries are affiliated to W.H.O., but assistance is given to those not affiliated, and Dr. Mackintosh gave as an example the assistance given to Egypt in controlling an epidemic of cholera.

Dr. Mackintosh emphasised that two-thirds of the world population live in undeveloped areas, where the expectation of life is only about 30 years, compared with 60 or more in well-developed areas. The organisation provides expert consultant services, demonstration teams, and facilities for the training of personnel in environmental sanitation. It grants individual fellowships to medical institutions, plans study groups, and provides technical assistance of all kinds, working in conjunction with other bodies, such as F.A.O. and Unicef. It possesses a comprehensive fact-finding service, from which information may be obtained on a multitude of subjects drawn from world-wide sources.

Dr. Mackintosh then described in detail how a working paper is prepared, and the stages through which it must go before being accepted.

Dr. Mackintosh felt we had a great deal to learn from W.H.O., and she found her visit a most stimulating experience.

A discussion followed in which Drs. Starkie, Ramage and Owen took part and a vote of thanks was proposed by Dr. Ramage.

Dr. Wyndham Parker.—Dr. Griffin referred to the retirement of Dr. Wyndham Parker from the post of County Medical Officer, Worcestershire, and referred to the very valuable service which Dr. Parker had rendered not only to this Branch but to public health as a whole. He proposed, and the members unanimously agreed, that a letter should be sent to Dr. Wyndham Parker, wishing him health and happiness in his retirement, and that an acknowledgment of Dr. Wyndham Parker's valuable services should be recorded in the minutes.

(*Continued on p. 126*)

NORTHERN BRANCH

President: Dr. J. V. Walker (M.O.H., Darlington C.B.).
Hon. Secretary: Dr. W. S. Walton, G.M. (M.O.H., Newcastle-on-Tyne C.B.).

A meeting of the Branch was held at Elswick Grange, Newcastle-on-Tyne, on Friday, January 18th, 1952. The President was in the chair and 18 members attended.

The Hon. Secretary reported the necessity of postponing the date of the annual dinner to April 4th, 1952, at the Royal Station Hotel. The President of the Society (Dr. W. G. Clark) would be the Guest of Honour.

Children's Homes Regulations, 1951.—The President raised the question of general medical services required from a Medical Officer of Health who had been appointed by his local authority as Medical Officer to a Children's Home, and the necessity for recognition by the Local Executive Council. The Ministry of Health had expressed the opinion that although it would be preferable for the children to be put on the panel of a general practitioner and for the M.O.H. to exercise a general supervision, there was no reason why the M.O.H. should not, if he wished, give general medical service to the children, the retention of fees being a matter of agreement between himself and his local authority.

Future Meetings.—The Hon. Secretary reported that Mr. C. J. L. Thurgar had agreed to address the Branch on March 28th, 1952; Prof. F. J. Nattrass would be asked in April, and Prof. Bradlaw during the autumn.

Black-listed Appointments.—The circumstances leading to the black-listing by the British Medical Association of the post of Medical Officer of Health to a local authority in the north-east in 1923 were discussed. It was felt that in future applications for membership there should be a common policy for both the Society and the British Medical Association.

Honours.—It was agreed that the Branch's congratulations be conveyed to Dr. J. M. Gibson and Dr. A. A. E. Newth on their award of the O.B.E.

Notification of Leprosy.—It was reported that the question of the notification of leprosy to Medical Officers of Health was still being pursued by the Society and the Association of Municipal Corporations.

NORTH-WESTERN BRANCH

President: Dr. A. M. M. Grierson (Dep. M.O.H., Manchester C.B.).
Hon. Secretary: Dr. J. S. G. Burnett (M.O.H., Preston C.B.).

A meeting of the Branch was held at Manchester Town Hall on Friday, January 11th, 1952, when 24 members attended.

Lymphocytic Meningitides and their Relationship to Anterior Poliomyelitis

The President introduced Dr. D. C. Liddle, who opened a discussion on the above. He referred first of all to those illnesses with lymphocytic meningeal response which are liable to cause difficulty in the diagnosis of poliomyelitis in its meningeal phase. He referred to the rapid progress in methods of diagnosis in recent years and to the modern work on virus culture neutralisation and complement fixation tests in relation to these conditions. Special reference was made to the comparatively recently isolated Coxsackie group of viruses and the clinical conditions other than meningitis caused by them. Reference was then made to the recent American work on poliomyelitis itself, to the improvements in the cultivation of the virus by the use of various human and animal tissues and thereby of the production of a better complement fixation test. Reference was made to the immunisation of animals and the current views on extra-neural multiplication of the virus.

A vigorous discussion ensued when the President raised the question of the action to be taken when an outbreak of poliomyelitis occurred.

Dr. Yule thanked Dr. Liddle for his critical analysis of the ragbag known as benign lymphocytic meningitis, many of which in practice were anything but benign. He felt that one of the main difficulties was a weakness in existing laboratory facilities and the solution to the problem really depended on an increase of these.

Dr. Duncan referred to cases of lymphocytic chorio-meningitis occurring in Manchester in the past two years in which the virus had been recovered. These had been of sub-acute onset with malaise, fever, sweating and anorexia from which apparent recovery took place so that the patient returned to work and was subsequently stricken with acute symptoms of meningitis. Clinically the diagnosis was not difficult and the geographical location proved useful, as all but two cases came from two small areas and 17 of them occurred within 130 yards of premises infested with mice carrying virus.

Dr. McClure enquired as to the period of illness and fatality rate in lymphocytic chorio-meningitis and it was stated that some of the cases had been extremely ill. No deaths were known to have occurred in this country though the Americans had described two fatalities.

In witty and felicitous mood Dr. Innes proposed a vote of thanks to the speaker. He referred to the change that had taken place in fever hospital working over the past 15 years and drew attention to the fact that now we needed to concern ourselves more with the fullness of life rather than its prolongation. He was grateful to Dr. Liddle for the critical review he had given.

An ordinary meeting of the Branch was held in Manchester on February 8th, 1952, when 19 members attended.

Discussions were opened by Dr. J. Yule and the Hon. Secretary on the position of the sanitary inspector in relation to the public health, the Draft Tuberculosis Regulations and the scheme for the control of medical manpower in time of war.

Variola Minor in the Rochdale Area

With reference to the editorial note in our last issue (p. 90), the infection remains confined to Rochdale C.B. and adjoining districts. Although numerous suspected cases have been investigated, up to noon on March 18th there was no confirmation of the presence of the disease elsewhere in the country.

Uncorrected notifications received at the General Register Office this year up to March 15th numbered 94. There have been no deaths. The distribution is shown in the following table:—

Week ended	16/2/52	23/2/52	1/3/52	8/3/52	15/3/52
Milnrow U.D. ...	1	2	1	1	1
Rochdale C.B. ...	—	16	6	59	5
Heywood B.	—	—	—	1	—
Littleborough U.D.	—	—	—	1	—
Totals 94	1	18	7	62	6

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